MDH Minnesota Department of Health

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide (MUCG) Version 12.0 for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment Advice (835)
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	This document was adopted into rule on August 14, 2017. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X221A1 Health Care Claim Payment Advice (835), hereinafter referred to as 005010X221A1, by entities subject to Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASC X12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 12.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X221A1 Health Care Claim Payment Advice (835). It was announced as an adopted rule in the Minnesota State Register, August 14, 2017 pursuant to Minnesota Statutes, sections 62J.536 and 62J.61. This document is available at no charge at: www.health.state.mn.us/asa.

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1 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program. The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

Minnesota Statutes, section 62J.03, Subd. 6 defines "group purchaser" as follows:

"Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Minnesota Statutes, section 62J.03, Subd. 8 defines “provider or health care provider” as follows:

"Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Minnesota Statutes, section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Minnesota Statutes, section 62J.51, Subd. 11a defines “health care clearinghouse” as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

1. *processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
2. *receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
3. *acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;*
4. *acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and*
5. *other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to applicability

Minnesota Statutes, section 62J.536, subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. *a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or*

ii. *another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.*

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

Note: The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction described under Code of Federal Regulations, title 45, part 162, subpart L, and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the state's rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (the ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271), hereinafter 005010X279A1). This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction with group purchasers not subject to HIPAA.

1.3 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: http://www.health.state.mn.us.

1.3.1 Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Phone: (651) 201-3570
Fax: (651) 201-3830
Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the AUC website at: http://www.health.state.mn.us/auc/index.html.

1.5 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at http://www.health.state.mn.us/auc/index.html for more information about best practices for implementing electronic health care transactions in Minnesota.

1.6 Document Changes

The content of this document is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for future updates or changes.

1.6.1 Process for updating this document

The process for updating this document, including: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document is available from MDH's website at http://www.health.state.mn.us/asa/index.html.

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v. 6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions.
9.0	November 11, 2014	Proposed as a rule for public comment on November 11, 2014. Version 9.0 incorporates changes proposed to v8.0.
10.0	March 9, 2015	Adopted into rule March 9, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.
11.0	May 22, 2017	Proposed as a rule for public comment May 22, 2017. Incorporates proposed changes to v10.0.

12.0	August 14, 2017	Adopted into rule August 14, 2017. Version 12.0 incorporates changes proposed in v10.0 and additional minor changes. Version 12.0 supersedes all previous versions.

2 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document is the ASC X12/005010X221A1 Health Care Claim Payment Advice (835) (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, ASC X12. All Rights Reserved), hereinafter described below as 005010X221A1. A copy of the full 005010X221A1 can be obtained from ASC X12 at: http://store.x12.org/store/.

2.1.1 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the 005010X221A1;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the 005010X221A1 in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536. In particular, the applicable information in this document must be appropriately incorporated by reference and/or displayed in companion guides of entities subject to Minnesota Statutes, section 62J.536, so as to meet any applicable requirements of CFR 45 § 162.1603, including compliance with the "ACME Health Plan, CORE v5010 Master Companion Guide Template, 005010, 1.2, March 2011 (incorporated by reference in § 162.920), as required by the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June 2012."

Please note:

Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

3 How to use this document

3.1 Classification and display of Minnesota-specific requirements

This document provides transaction specific information to be used in conjunction with the 005010X221A1 and other applicable information and specifications noted in section 2.0 above. Additional information needed to comply with Minnesota Statutes, section 62J.536 is provided in the table described in section 4.0 and in Appendices A, B, C, and D.

The table in section 4.0 contains a row for each segment for which there is additional information over and above the information in the 005010X221A1. The table shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

Please note: The following sub-sections of this Companion Guide reference several standard health care transactions as follows:

- ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), is referred to in the subsequent sub-sections as “005010X221A1”, “835,” “the 835,” or “the 835 transaction.”
- ASC X12/005010X222A1 Health Care Claim: Professional (837), ASC X12/005010X223A2 Health Care Claim: Institutional (837) and ASCX12/005010X224A2 Health Care Claim: Dental (837), are referred to in the subsequent sub-sections collectively as “837,” or “the 837.”
- The 005010X222A1 is referred to as “837P” and the 005010X224A2 is referred to as “837D.”

3.2 Information About the Health Care Claim Payment Advice (835) Transaction

3.2.1 Business Terminology

For purposes of this document, the following terms have the meaning given to them in this section.

3.2.1.1 Adjustment

As defined in the 005010X221A1 TR3, “the term adjustment refers to changes to the amount paid on a claim, service or remittance advice versus the original submitted charge/bill. Adjustment does not refer to changing or correcting a previous adjudication of a claim.”

3.2.1.2 Claim Submitter’s Identifier

The Claim Submitter’s Identifier reported in the claim within the 837 is returned in the 835 transaction for tracking purposes. The Claim Submitter’s Identifier is located in the 837 in CLM01, and for the NCPDP claims, return the Prescription number from 402-D2. These values are returned in CLP01 of the 005010X221A1.

3.2.2 Correlating Provider Information from the Health Care Claim (837) Transaction to the Health Care Claim Payment/Advice (835) Transaction

The 835 transaction identifies two primary provider types, the payee and the servicing/rendering provider. The payee is reported once in each 835 transaction in loop 1000B.

If no other agreement exists between the provider and group purchaser:

- The 835 payee corresponds to the 837 billing provider or the NCPDP service provider ID.
- For providers who participate with the group purchaser and are required to complete enrollment forms as part of the contracting process, the payment address submitted on the claim transaction may not be the address where payment is ultimately sent for the claim. The group purchaser in this case may use the payment address from the enrollment form or within the contract rather than the address that is submitted in the 2010AB loop of an electronic claim. The contracted provider must request address changes to the group purchaser records according to the instructions within the provider contract.
- When a pay-to provider loop is sent in addition to billing provider loop, the payment should be sent to the pay-to loop address, unless the group purchaser utilizes an enrollment form or a contract.

The 835 claim servicing/rendering provider corresponds to the 837P and 837D claim rendering provider or the NCPDP service provider. The claim servicing/rendering provider may be reported once for each 835 claim in loop 2100/NM1 (NM101=82). The servicing/rendering provider is only required when different from the payee.

The 835 line rendering provider identifier corresponds to the 837P and 837D service line rendering provider. The line rendering provider identifier may also be reported once for each

835 service line in loop 2110/REF (REF01=G2 or HPI). The line rendering provider identifier is only required when different from the claim servicing/rendering provider.

3.2.3 Relationship and Importance of Accurate and Balanced 835 Transactions for 837 Coordination of Benefits COB Situations

It is imperative that 835 transactions balance, contain accurate information, and utilize active CARC, RARC or NCPDP reject codes. After the receipt and posting of the 835 payment and/or adjustment data, this data must be used in 837 Coordination of Benefits (COB) situations. When submitting COB claims to secondary/tertiary payers, the provider needs to populate the appropriate 837 segments with the prior payer's payment and/or adjustment data. If this data is inaccurate, or does not balance, then the subsequent 835 payment and remittance advice from the secondary/tertiary payer may be delayed, or inaccurate.

See Appendix C for detailed COB examples.

3.2.4 Using Inactive CARC and RARC

Inactive CARC and RARC can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a Stop date of 02/01/2007 would not be able to be used by a payer in a CAS segment in a claim payment/advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication (CLP02 values like "1", "2", "3" or "19"). The code would still be available to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or payer to a secondary or tertiary payer, or an 835 from the original payer to the provider as a reversal of the original adjudication (CLP02 value "22"). The deactivated code may be used in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

3.2.5 Formatting Requirements

Segments Reporting Multiple Values from Same Code Set: Some segments (e.g., CAS and PLB) have multiple elements that contain values from the same code set. When it is necessary to report multiple values, they must be populated sequentially within the segment; gaps between data elements are not allowed.

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4 ASC X12/005010X221A1 Health Care Claim Payment Advice (835) Transaction: Transaction Specific Information

4.1 Introduction to Table

The following table contains information needed to implement the 005010X221A1 Health Care Claim Payment Advice (835) Transaction. A description of this table is provided in Section 3.0 above.

Please also see section 3.2 above.

4.2 005010X221A1 (835) Transaction Table

005010X221A1 (835) Transaction Specific Information This table summarizes transaction specific information to be used in conjunction with the 005010X221A1 and any other applicable information and specifications noted in section 3.2 above.			
Loop	Segment	Data Element (if applicable)	Value Definition and notes
ST Transaction Set Header	BPR Financial Information	BPR01 Transaction Handling Code	C, H, or I
ST Transaction Set Header	BPR Financial Information	BPR03 Credit/Debit Flag Code	C
ST	BPR	BPR04	ACH, CHK, FWT, NON

005010X221A1 (835) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X221A1 and any other applicable information and specifications noted in section 3.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and notes
Transaction Set Header	Financial Information	Payment Method Code	
1000B Payee Identification	REF Payee Additional Identification	REF01 Reference Identification Qualifier	D3, PQ, TJ PQ identifies the Payer assigned Payee identifier
2100 Claim Payment Information	CLP Claim Payment Information	CLP06 Claim Filing Indicator Code	ZZ may be used by pharmacy payers to identify Medicare retro-active Low Income Subsidy (LIS) adjustment of pharmacy claims using the 005010X221A1 with their long term care (LTC) business partners. Otherwise, ZZ is not an appropriate code because this document does not support the use of a mutually defined qualifier.
2100 Claim Payment Information	NM1 Insured Name	NM102 Entity Type Qualifier	1, 2. An example for value "2" would be Worker's Compensation where the employer is the insured.
2100 Claim Payment Information	NM1 Service Provider Name	NM108 Identification Code Qualifier	FI, PC, and XX
2100	REF	REF02	See Appendix D for instructions for reporting Medicaid "PMAP" codes.

005010X221A1 (835) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X221A1 and any other applicable information and specifications noted in section 3.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and notes
Claim Payment Information	Other claim related identification	Reference Identification	
2100 Claim Payment Information	PER Claim Contact Information		Required for Workers' Compensation, Auto and Property and Casualty payments.
2110 Service Payment Information	REF Rendering Provider Information	REF01 Reference Identification Qualifier	G2, HPI
2110 Service Payment Information	AMT Service Supplemental Amount	AMT01 Amount Qualifier Code	B6, KH, T, T2

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5 List of Appendices

Appendix A: Minnesota Crosswalk for the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes (RARC)

Appendix B: Workers Compensation Reporting of Reason for a Denial or Reduction of Payment

Appendix C: Coordination of Benefits Examples

Appendix D: Prepaid Medical Assistance Program (PMAP) Program Codes for Medicaid Remittances

Appendix E. Reporting All Patients Refined Diagnosis Related Groups (APR-DRG)

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5.1 Appendix A: Minnesota Crosswalk for the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes (RARC)

5.1.1 Use of Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes (CAGC), and Remittance Advice Remark Codes (RARC)

5.1.1.1 Sources of Information and Requirements

This appendix lists the CARC, CAGC, and RARC for use by group purchasers and providers subject to Minnesota Statutes, section 62J.536 as follows:

1. If the applicable business scenario is described in the "CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360" use the CARC, RARC, and CAGC in the CORE requirements. Information about CORE and the rule above are available at: http://www.caqh.org/CORE_phase3.php. (Note: The CORE rule was adopted as part of federal Operating Rules for Electronic Funds Transfer (EFT) and Remittance Advice Transactions.)

2. If the applicable business scenario is not described in the CORE rule above, but is described by the scenario in section 5.1.5 below, use the code combinations in section 5.1.5 for the scenario "Additional Information Required – Missing/Invalid/Incomplete Information From the Patient. (Refers to situations where additional information is needed from the patient.)"

If the business scenario is not described by choices 1 or 2 above, group purchasers may create new scenarios that do not conflict with those above, and may use applicable, appropriate code combinations, consistent with the above referenced CORE requirements. Group purchasers should submit new scenarios to CORE for consideration in an updated CORE rule.

Note: For Property and Casualty lines of business ONLY, RARC N202 may be used with any CARC. For all other payers, RARC N202 may only be used as prescribed in this Appendix A.

5.1.2 Pharmacy Transactions

Pharmacy transactions may also require additional codes, and pharmacy may use the code combinations described above and the payment/reject codes maintained by the National Council of Prescription Drug Plans (NCPDP) as needed and appropriate. (NCPDP payment/reject codes – see http://www.ncpdp.org for more information)

5.1.3 Workers' Compensation

For workers compensation, see appendix B.

5.1.4 CARC and RARC Updates/Changes

As noted below, national organizations are responsible for maintenance of CARC and RARC and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes.

CARC are updated (additions, deletions, changes) three times/year by the Joint Claim Adjustment Reason/Health Care Claim Status Reason Code Maintenance Committee. These updates are published by Washington Publishing Company at http://www.wpc-edi.com.

RARC are maintained by the federal Centers for Medicare & Medicaid Services (CMS). Updates to the Remark Codes (additions, changes, deletions) are published by Washington Publishing Company at http://www.wpc-edi.com/.

5.1.5 RARC and CAGC to use with CARC 227 for the business scenario "Additional Information Required – Missing/Invalid/Incomplete Information from the Patient"

The business scenario "Additional Information Required – Missing/Invalid/Incomplete Information from the Patient" refers to situations where additional information is needed from the patient, including situations where the information is required from the patient due to lack of a participating provider agreement.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
M19	Missing oxygen certification/re-certification.
M20	Missing/incomplete/invalid HCPCS.
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22	Missing/incomplete/invalid number of miles traveled.
M23	Missing invoice.
M24	Missing/incomplete/invalid number of doses per vial.
M29	Missing operative note/report.
M30	Missing pathology report.
M31	Missing radiology report.
M44	Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence code(s).
M46	Missing/incomplete/invalid occurrence span code(s).
M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
M49	Missing/incomplete/invalid value code(s) or amount(s).
M50	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s).
M52	Missing/incomplete/invalid "from" date(s) of service.
M53	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
M56	Missing/incomplete/invalid payer identifier.
M59	Missing/incomplete/invalid "to" date(s) of service.
M60	Missing Certificate of Medical Necessity.
M62	Missing/incomplete/invalid treatment authorization code.
M64	Missing/incomplete/invalid other diagnosis.
M67	Missing/incomplete/invalid other procedure code(s).
M76	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid/inappropriate place of service.
M79	Missing/incomplete/invalid charge.
M81	You are required to code to the highest level of specificity.
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
M122	Missing/incomplete/invalid level of subluxation.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.
M125	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.
M127	Missing patient medical record for this service.
M129	Missing/incomplete/invalid indicator of x-ray availability for review.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing physician financial relationship form.
M132	Missing pacemaker registration form.
M135	Missing/incomplete/invalid plan of treatment.
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
M141	Missing physician certified plan of care.
M142	Missing American Diabetes Association Certificate of Recognition.
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.
MA30	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35	Missing/incomplete/invalid number of lifetime reserve days.
MA36	Missing/incomplete/invalid patient name.
MA37	Missing/incomplete/invalid patient's address.
MA39	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
MA41	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA58	Missing/incomplete/invalid release of information indicator.
MA60	Missing/incomplete/invalid patient relationship to insured.
MA61	Missing/incomplete/invalid social security number or health insurance claim number.
MA63	Missing/incomplete/invalid principal diagnosis.
MA64	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.
MA66	Missing/incomplete/invalid principal procedure code.
MA69	Missing/incomplete/invalid remarks.
MA70	Missing/incomplete/invalid provider representative signature.
MA71	Missing/incomplete/invalid provider representative signature date.
MA75	Missing/incomplete/invalid patient or authorized representative signature.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA81	Missing/incomplete/invalid provider/supplier signature.
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90	Missing/incomplete/invalid employment status code for the primary insured.
MA92	Missing plan information for other insurance.
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
MA99	Missing/incomplete/invalid Medigap information.
MA100	Missing/incomplete/invalid date of current illness or symptoms.
MA110	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 the test(s) and/or the performing laboratory's name and address.
MA112	Missing/incomplete/invalid group practice information.
MA113	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.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA120	Missing/incomplete/invalid CLIA certification number.
MA121	Missing/incomplete/invalid x-ray date.
MA122	Missing/incomplete/invalid initial treatment date.
MA128	Missing/incomplete/invalid FDA approval number.
MA130	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.
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
N3	Missing consent form.
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
M23	Missing invoice.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N26	Missing itemized bill/statement.
N27	Missing/incomplete/invalid treatment number.
N28	Consent form requirements not fulfilled.
N31	Missing/incomplete/invalid prescribing provider identifier.
N37	Missing/incomplete/invalid tooth number/letter.
N39	Procedure code is not compatible with tooth number/letter.
N40	Missing radiology film(s)/image(s).

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N42	Missing mental health assessment.
N46	Missing/incomplete/invalid admission hour.
N48	Claim information does not agree with information received from other insurance carrier.
N49	Court ordered coverage information needs validation.
N50	Missing/incomplete/invalid discharge information.
N53	Missing/incomplete/invalid point of pick-up address.
N57	Missing/incomplete/invalid prescribing date.
N58	Missing/incomplete/invalid patient liability amount.
N61	Rebill services on separate claims.
N62	Dates of service span multiple rate periods. Resubmit separate claims.
N63	Rebill services on separate claim lines.
N64	The "from" and "to" dates must be different.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
N75	Missing/incomplete/invalid tooth surface information.
N76	Missing/incomplete/invalid number of riders.
N77	Missing/incomplete/invalid designated provider number.
N79	Service billed is not compatible with patient location information.
N80	Missing/incomplete/invalid prenatal screening information.
N81	Procedure billed is not compatible with tooth surface code.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
MA04	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.
MA92	Missing plan information for other insurance.
N108	Missing/incomplete/invalid upgrade information.
N146	Missing screening document.
N147	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.
N149	Rebill all applicable services on a single claim.
N150	Missing/incomplete/invalid model number.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.
N175	Missing review organization approval.
N178	Missing pre-operative images/visual field results.
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
N190	Missing contract indicator.
N197	The subscriber must update insurance information directly with the payer.
N203	Missing/incomplete/invalid anesthesia time/units.
N205	Information provided was illegible.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N207	Missing/incomplete/invalid weight.
N208	Missing/incomplete/invalid DRG code.
N209	Missing/incomplete/invalid taxpayer identification number (TIN).
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).
N221	Missing Admitting History and Physical report.
N222	Incomplete/invalid Admitting History and Physical report.
N223	Missing documentation of benefit to the patient during initial treatment period.
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.
N227	Incomplete/invalid Certificate of Medical Necessity.
N228	Incomplete/invalid consent form.
N229	Incomplete/invalid contract indicator.
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
N232	Incomplete/invalid itemized bill/statement.
N233	Incomplete/invalid operative note/report.
N234	Incomplete/invalid oxygen certification/re-certification.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N235	Incomplete/invalid pacemaker registration form.
N236	Incomplete/invalid pathology report.
N237	Incomplete/invalid patient medical record for this service.
N238	Incomplete/invalid physician certified plan of care.
N239	Incomplete/invalid physician financial relationship form.
N240	Incomplete/invalid radiology report.
N241	Incomplete/invalid review organization approval.
N242	Incomplete/invalid radiology film(s)/image(s).
N243	Incomplete/invalid/not approved screening document.
N244	Incomplete/Invalid pre-operative images/visual field results.
N245	Incomplete/invalid plan information for other insurance .
N247	Missing/incomplete/invalid assistant surgeon taxonomy.
N248	Missing/incomplete/invalid assistant surgeon name.
N249	Missing/incomplete/invalid assistant surgeon primary identifier.
N250	Missing/incomplete/invalid assistant surgeon secondary identifier.
N251	Missing/incomplete/invalid attending provider taxonomy.
N252	Missing/incomplete/invalid attending provider name.
N253	Missing/incomplete/invalid attending provider primary identifier.
N254	Missing/incomplete/invalid attending provider secondary identifier.
N255	Missing/incomplete/invalid billing provider taxonomy.
N256	Missing/incomplete/invalid billing provider/supplier name.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
N258	Missing/incomplete/invalid billing provider/supplier address.
N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
N260	Missing/incomplete/invalid billing provider/supplier contact information.
N261	Missing/incomplete/invalid operating provider name.
N262	Missing/incomplete/invalid operating provider primary identifier.
N263	Missing/incomplete/invalid operating provider secondary identifier.
N264	Missing/incomplete/invalid ordering provider name.
N265	Missing/incomplete/invalid ordering provider primary identifier.
N266	Missing/incomplete/invalid ordering provider address.
N267	Missing/incomplete/invalid ordering provider secondary identifier.
N268	Missing/incomplete/invalid ordering provider contact information.
N269	Missing/incomplete/invalid other provider name.
N270	Missing/incomplete/invalid other provider primary identifier.
N271	Missing/incomplete/invalid other provider secondary identifier.
N272	Missing/incomplete/invalid other payer attending provider identifier.
N273	Missing/incomplete/invalid other payer operating provider identifier.
N274	Missing/incomplete/invalid other payer other provider identifier.
N275	Missing/incomplete/invalid other payer purchased service provider identifier.
N276	Missing/incomplete/invalid other payer referring provider identifier.
N277	Missing/incomplete/invalid other payer rendering provider identifier.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N278	Missing/incomplete/invalid other payer service facility provider identifier.
N279	Missing/incomplete/invalid pay-to provider name.
N280	Missing/incomplete/invalid pay-to provider primary identifier.
N281	Missing/incomplete/invalid pay-to provider address.
N282	Missing/incomplete/invalid pay-to provider secondary identifier.
N283	Missing/incomplete/invalid purchased service provider identifier.
N284	Missing/incomplete/invalid referring provider taxonomy.
N285	Missing/incomplete/invalid referring provider name.
N286	Missing/incomplete/invalid referring provider primary identifier.
N287	Missing/incomplete/invalid referring provider secondary identifier.
N288	Missing/incomplete/invalid rendering provider taxonomy.
N289	Missing/incomplete/invalid rendering provider name.
N290	Missing/incomplete/invalid rendering provider primary identifier.
N291	Missing/incomplete/invalid rendering provider secondary identifier.
N292	Missing/incomplete/invalid service facility name.
N293	Missing/incomplete/invalid service facility primary identifier.
N294	Missing/incomplete/invalid service facility primary address.
N295	Missing/incomplete/invalid service facility secondary identifier.
N296	Missing/incomplete/invalid supervising provider name.
N297	Missing/incomplete/invalid supervising provider primary identifier.
N298	Missing/incomplete/invalid supervising provider secondary identifier.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N299	Missing/incomplete/invalid occurrence date(s).
N300	Missing/incomplete/invalid occurrence span date(s).
N301	Missing/incomplete/invalid procedure date(s).
N302	Missing/incomplete/invalid other procedure date(s).
N303	Missing/incomplete/invalid principal procedure date.
N304	Missing/incomplete/invalid dispensed date.
N305	Missing/incomplete/invalid accident date.
N306	Missing/incomplete/invalid acute manifestation date.
N307	Missing/incomplete/invalid adjudication or payment date.
N308	Missing/incomplete/invalid appliance placement date.
N309	Missing/incomplete/invalid assessment date.
N310	Missing/incomplete/invalid assumed or relinquished care date.
N311	Missing/incomplete/invalid authorized to return to work date.
N312	Missing/incomplete/invalid begin therapy date.
N313	Missing/incomplete/invalid certification revision date.
N314	Missing/incomplete/invalid diagnosis date.
N315	Missing/incomplete/invalid disability from date.
N316	Missing/incomplete/invalid disability to date.
N317	Missing/incomplete/invalid discharge hour.
N318	Missing/incomplete/invalid discharge or end of care date.
N319	Missing/incomplete/invalid hearing or vision prescription date.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N320	Missing/incomplete/invalid Home Health Certification Period.
N321	Missing/incomplete/invalid last admission period.
N322	Missing/incomplete/invalid last certification date.
N323	Missing/incomplete/invalid last contact date.
N324	Missing/incomplete/invalid last seen/visit date.
N325	Missing/incomplete/invalid last worked date.
N326	Missing/incomplete/invalid last x-ray date.
N327	Missing/incomplete/invalid other insured birth date.
N328	Missing/incomplete/invalid Oxygen Saturation Test date.
N329	Missing/incomplete/invalid patient birth date.
N330	Missing/incomplete/invalid patient death date.
N331	Missing/incomplete/invalid physician order date.
N332	Missing/incomplete/invalid prior hospital discharge date.
N333	Missing/incomplete/invalid prior placement date.
N334	Missing/incomplete/invalid re-evaluation date.
N335	Missing/incomplete/invalid referral date.
N336	Missing/incomplete/invalid replacement date.
N337	Missing/incomplete/invalid secondary diagnosis date.
N338	Missing/incomplete/invalid shipped date.
N339	Missing/incomplete/invalid similar illness or symptom date.
N340	Missing/incomplete/invalid subscriber birth date.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N341	Missing/incomplete/invalid surgery date.
N342	Missing/incomplete/invalid test performed date.
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
N346	Missing/incomplete/invalid oral cavity designation code.
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
N354	Incomplete/invalid invoice.
N359	Missing/incomplete/invalid height.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
N378	Missing/incomplete/invalid prescription quantity.
N382	Missing/incomplete/invalid patient identifier.
N388	Missing/incomplete/invalid prescription number.
N391	Missing emergency department records.
N392	Incomplete/invalid emergency department records.
N393	Missing progress notes/report.
N394	Incomplete/invalid progress notes/report.
N395	Missing laboratory report.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N396	Incomplete/invalid laboratory report.
N398	Missing elective consent form.
N399	Incomplete/invalid elective consent form.
N401	Missing periodontal charting.
N402	Incomplete/invalid periodontal charting.
N403	Missing facility certification.
N404	Incomplete/invalid facility certification.
N434	Missing/Incomplete/Invalid Present on Admission indicator.
N439	Missing anesthesia physical status report/indicators.
N440	Incomplete/invalid anesthesia physical status report/indicators.
N443	Missing/incomplete/invalid total time or begin/end time.
N445	Missing document for actual cost or paid amount.
N446	Incomplete/invalid document for actual cost or paid amount.
N451	Missing Admission Summary Report.
N452	Incomplete/invalid Admission Summary Report.
N453	Missing Consultation Report.
N454	Incomplete/invalid Consultation Report.
N455	Missing Physician Order.
N456	Incomplete/invalid Physician Order.
N457	Missing Diagnostic Report.
N458	Incomplete/invalid Diagnostic Report.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N459	Missing Discharge Summary.
N460	Incomplete/invalid Discharge Summary.
N461	Missing Nursing Notes.
N462	Incomplete/invalid Nursing Notes.
N463	Missing support data for claim.
N464	Incomplete/invalid support data for claim.
N465	Missing Physical Therapy Notes/Report.
N466	Incomplete/invalid Physical Therapy Notes/Report.
N467	Missing Tests and Analysis Report.
N468	Incomplete/invalid Report of Tests and Analysis Report.
N471	Missing/incomplete/invalid HIPPS Rate Code.
N473	Missing certification.
N474	Incomplete/invalid certification.
N475	Missing completed referral form.
N476	Incomplete/invalid completed referral form.
N477	Missing Dental Models.
N478	Incomplete/invalid Dental Models.
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N481	Missing Models.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N482	Incomplete/invalid Models.
N485	Missing Physical Therapy Certification.
N486	Incomplete/invalid Physical Therapy Certification.
N487	Missing Prosthetics or Orthotics Certification.
N488	Incomplete/invalid Prosthetics or Orthotics Certification.
N489	Missing referral form.
N490	Incomplete/invalid referral form.
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.
N493	Missing Doctor First Report of Injury.
N494	Incomplete/invalid Doctor First Report of Injury.
N495	Missing Supplemental Medical Report.
N496	Incomplete/invalid Supplemental Medical Report.
N497	Missing Medical Permanent Impairment or Disability Report.
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.
N499	Missing Medical Legal Report.
N500	Incomplete/invalid Medical Legal Report.
N501	Missing Vocational Report.
N502	Incomplete/invalid Vocational Report.
N503	Missing Work Status Report.
N504	Incomplete/invalid Work Status Report.
N519	Invalid combination of HCPCS modifiers.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N542	Missing income verification.
N543	Incomplete/invalid income verification.
N554	Missing/Incomplete/Invalid Family Planning Indicator.
N555	Missing medication list.
N556	Incomplete/invalid medication list.
N570	Missing/incomplete/invalid credentialing data.
N582	Benefits suspended pending the patient's cooperation
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.
N667	Missing prescription.
N668	Incomplete/invalid prescription.
N675	Additional information is required from the injured party
N678	Missing post-operative images/visual field results.
N679	Incomplete/Invalid post-operative images/visual field results.
N680	Missing/Incomplete/Invalid date of previous dental extractions.
N681	Missing/Incomplete/Invalid full arch series.
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.
N683	Missing/Incomplete/Invalid prior treatment documentation.
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.
N705	Incomplete/invalid documentation.
N706	Missing documentation.
N707	Incomplete/invalid orders.
N708	Missing orders.
N709	Incomplete/invalid notes.
N710	Missing notes.
N711	Incomplete/invalid summary.
N712	Missing summary.
N713	Incomplete/invalid report.
N714	Missing report.
N715	Incomplete/invalid chart.
N716	Missing chart.
N717	Incomplete/Invalid documentation of face-to-face examination.
N718	Missing documentation of face-to-face examination.
N729	Missing patient medical/dental record for this service.
N730	Incomplete/invalid patient medical/dental record for this service.
N731	Incomplete/Invalid mental health assessment.
N736	Incomplete/invalid Sleep Study Report.
N737	Missing Sleep Study Report.
N738	Incomplete/invalid Vein Study Report.

Use the CAGC "PR" and the RARC listed below for CARC 227, "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)."	
RARC to use with CAGC PR and CARC 227	RARC description
N739	Missing Vein Study Report.
N745	Missing Ambulance Report.
N746	Incomplete/invalid Ambulance Report.
N749	Missing Blood Gas Report.
N750	Incomplete/invalid Blood Gas Report.
N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).
N753	Missing/incomplete/invalid Attachment Control Number.
N754	Missing/incomplete/invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.
N755	Missing/incomplete/invalid ICD Indicator on the 1500 Claim Form.
N756	Missing/incomplete/invalid point of drop-off address.

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5.2 Appendix B: Workers Compensation Reporting of Reason for a Denial or Reduction of Payment

5.2.1 Scope:

The Minnesota Uniform Companion Guide and this Appendix do not modify any requirement in the workers' compensation statutes and rules governing the legal basis for denial or reduction of payment or the notice that must be given to the injured employee and the health care provider about payment or denial of medical charges or treatment.

This appendix applies only to remittance advices for workers' compensation claims to meet specific Minnesota workers' compensation jurisdictional requirements in Minn. Stat. § 176.135, subd. 6 and Minn. R. 5221.0600.

5.2.2 Enumerated Code List:

For purposes of this Appendix, an enumerated code list describes the basis for adjustment or denial of a workers' compensation medical bill or charge. Each enumerated code identifies the applicable Minnesota rule, part, and subpart or, if no rule applies, the applicable Minnesota statute or other legal basis for the adjustment or denial. An enumerated code must be used in addition to the applicable CARC/RARC code as described in section IV.

Examples:

- Code 176.136 S 1a (a) means Minnesota Statutes, section 176.136, subdivision 1a, paragraph (a).
- Code 5221.4035 S 5 D means Minnesota Rules, Part 5221.4035, subpart 5, item D.

5.2.3 Web Site URL:

The Minnesota Department of Labor and Industry (Department) maintains a web site URL that has links to the text of the statutes and rules used by workers' compensation payers as a basis to reduce or deny a charge. The URL address that must be referred to in loop 1000A segment PER is the URL website that is maintained by the Minnesota Department of Labor and Industry: www.dli.mn.gov. The URL website is required anytime a charge is reduced or denied.

Example: PER*IC**UR* www.dli.mn.gov~

5.2.4 Instructions for using CARC/RARCs:

Items 1 to 11 describe how the claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) must be used at the claim or line level.

1. Use claim adjustment reason code P2 to deny payment on the basis that primary liability for the injury or illness being treated is denied.
2. Use claim adjustment reason code P4 to deny payment on the basis that the treatment is due to a prior workers' compensation injury that is the liability of a previous workers' compensation carrier.
3. Use claim adjustment reason code 219 to deny payment on the basis that the treatment or service is for a condition not related to the admitted workers' compensation injury.
4. Use claim adjustment reason code P12, along with any other applicable remittance advice remark code, to adjust a charge based on the maximum fee allowed under the workers' compensation relative value fee schedule according to Minn. Stat. § 176.136, subd. 1a and Minnesota Rules, parts 5221.4005 to 5221.4070.
5. Use claim adjustment reason code P13 to adjust a charge to 85% of the provider's usual and customary charge according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. Rules 5221.0500, subp. 2 (B) (1).
6. Use claim adjustment reason code P13 to adjust a charge to 85% of the prevailing charges for similar treatment according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. Rules 5221.0500, subp. 2 (B) (2).
7. Use claim adjustment reason codes 50, 56, or 152, as applicable, to adjust a charge on the basis that the service, article or supply is not reasonable and necessary to cure or relieve the effects of the injury or illness; or is not consistent with Minnesota workers' compensation treatment parameters (Minnesota Rules 5221.6010 to 5221.6600).
8. Use claim adjustment reason code 96 and remittance advice remark code N381 to adjust a charge based on a contractual reimbursement agreement between the provider and payer.
9. To adjust a charge based on a statute or rule for reasons other than those described in items 1 to 8, use any claim adjustment reason code that includes this language:

   > "Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF), if present" and remittance advice remark code that best describes the adjustment." **(Claim adjustment reason codes with this language are listed in section 5.2.5 of this Appendix B.)**

   If there is no claim adjustment reason code that accurately describes the adjustment and includes the quoted language, use claim adjustment reason code P13.

10. If an entire bill is denied at the claim level, use the Insurance Policy Number Segment (Loop 2100) Other Claim Related Information REF. Use the qualifier 'IG' for bills that are adjusted at the claim level.

    Example #1:

    Claim adjustment reason code P2 is used when an entire bill is denied on the basis that primary liability for the injury or illness being treated is denied per Minnesota Statute 176.135 subdivision 6 (1).

    - In REF 01, use qualifier IG
    - In REF 02 specify the appropriate code for the applicable statute, followed by the URL for the website that is maintained by the Minnesota Department of Labor and Industry to describe enumerated codes: www.dli.mn.gov.

    Example: REF*IG*176.135 S 6 (1) www.dli.mn.gov.

11. If a bill is reduced at the line level, use the Healthcare Policy Identification Segment (Loop 2110) to specify the appropriate code for the most specific statute and subdivision or rule part and subpart supporting the adjustment.

    Example #2:

    Claim adjustment reason code P12 is used when a line item of a bill is reduced based solely on the maximum fee in the Minnesota workers compensation medical fee schedule rule per Minnesota Statute 176.136 subdivision 1a (1) and Minnesota Rule 5221.4020, subpart 1b, item A (1).

    - In REF01, use qualifier 0K
    - In REF02, specify the appropriate code for the applicable statute, rule or law.

    Example: REF*0K*176.136 S 1a (1); 5221.4020 S1b A (1)~

    Example # 3:

    Claim adjustment reason code P12 is used and a line item of a bill is reduced based on the Minnesota workers compensation medical fee schedule multiple procedure rule per Minnesota Statute 176.136 subdivision 1a (a)and Minnesota Rule 5221.4035, subpart 5, item D.

    - In REF01, use qualifier 0K
    - In REF02, specify the appropriate code for the applicable statute, rule or law

    Example: REF*0K*176.136 S 1a (a); 5221.4035 S 5 D~

5.2.5 Allowed CARC codes:

*Only Claim Adjustment Reason Codes (CARCs) with the language: "**Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present**" are allowed to be used in Minnesota workers' compensation transactions. Currently CARC codes with this language are:

4, 5, 6, 7, 8, 9, 10, 11, 12, 16, 40, 49, 50, 51, 54, 55, 56, 58, 59, 61, 96, 97,107, 108, 152, 167, 170, 171, 172, 179, 183, 184, 185, 219, 222, 231, B7, B8, B15, P2, P4, P6, P8, P12, P13 and P14.

Note: CARC are updated (additions, deletions, changes) three times/year by the ANSI X12N Health Care Claim Adjustment Reason Code/Health Care Claim Status Code Committee. These updates are published by Washington Publishing Company at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. This Guide and Appendix incorporate by reference any CARC changes.

5.3 Appendix C: Coordination of Benefits (COB) Examples

Note: The intent of the examples provided in this section of the document is to be a reference for Group Purchasers and Providers. The examples are not to be used as an exhaustive guide to code HIPAA or Minnesota requirements. These examples are not to be interpreted as the only scenarios associated with a particular requirement, and are not intended to be all inclusive. Group Purchasers and Providers must look within their own particular application systems to see if any other scenarios may fit the requirements. These examples typically include only the minimum required data; however, in some cases, additional data may be required to be reported by Group Purchasers, as defined by benefit designs or this Minnesota Uniform Companion Guide.

The following Section contains three EDI examples of an ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) primary transaction and the corresponding secondary 005010X221A1 transaction.

Example 1 – Secondary group purchaser allows less than primary group purchaser

The claim total is $2500.00, and the primary group purchaser allows $1800.00 based on the contract with the provider (noted in B6 segment). The $700.00 disallowance is sent in the 005010X221A1 transaction with the CO-45 CARC code. The primary group purchaser pays $1300.00 on the allowed amount, and leaves $500.00 as the patient's responsibility (PR).

CLP*id*1*2500*1300*500*…
SVC*HC:proc*2500*1300*…
CAS*CO*45*700~
CAS*PR*1*500~
AMT*B6*1800~

When the secondary group purchaser considers the $2500.00 claim, the payment and disallowed amounts from the primary group purchaser ($2000.00 total) are sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser would allow $1450.00 on the $2500.00 claim, as noted in the B6 segment. This $1450.00 is deducted from the $1800.00 already allowed, so the secondary group purchaser disallows an additional $350.00 and sends that amount in the 005010X221A1 transaction with the CO-45 CARC code. This $350.00 is deducted from the $500.00 patient responsibility (PR) left by the primary group purchaser. The secondary group purchaser pays $100.00 on the claim, and leaves $50.00 as patient responsibility (PR). The secondary payment is based on a lower allowed amount than the primary payment. The submitted charge is $2,500.

CLP*id*2*2500*100*50*…
SVC*HC:proc*2500*100*…
CAS*OA*23*2000~

CAS*PR*3*50~
CAS*CO*45*350~
AMT*B6*1450~

Example 2 – Secondary group purchaser allows more than primary group purchaser

The claim total is $2500.00, and the primary group purchaser allows $1450.00 based on the contract with the provider (noted in B6 segment). The $1050.00 disallowance is sent in the 005010X221A1 transaction with the CO-45 CARC code. The primary group purchaser pays $1300.00 on the allowed amount, and leaves $150.00 as the patient's responsibility (PR).

CLP*id*1*2500*1300*150*…
SVC*HC:proc*2500*1300*…
CAS*CO*45*1050~
CAS*PR*1*150~
AMT*B6*1450~

When the secondary group purchaser considers the $2500.00 claim, the payment and disallowed amounts from the primary group purchaser ($2350.00 total) are sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser would allow $1800.00 on the $2500.00 claim, as noted in the B6 segment. Since the secondary group purchaser would allow more than the primary allowed on this claim, there is no additional contract adjustment (CARC transaction). The secondary group purchaser pays $100.00 on the claim, and leaves $50.00 as patient responsibility (PR).

CLP*id*2*2500*100*50*…
SVC*HC:proc*2500*100*…
CAS*OA*23*2350~
CAS*PR*3*50~
AMT*B6*1800~

Example 3 – Primary group purchaser allows full claim amount, secondary group purchaser does not

The claim total is $2500.00, and that amount is fully allowed by the group purchaser as noted in the B6 segment. There is no contractual adjustment, but $1200.00 is assigned as patient responsibility (PR). The primary payment is $1300.00.

CLP*id*1*2500*1300*1200*…
SVC*HC:proc*2500*1300*…
CAS*PR*1*1200~
AMT*B6*2500~

When the secondary group purchaser considers the $2500.00 claim, the payment amount from the primary group purchaser ($1300.00) is sent in the 005010X221A1 transaction with the OA-23 CARC code. The secondary group purchaser allows $1800.00 as noted in the B6 segment, which is less than the primary allowed. As a result, the secondary group purchaser applies a $700.00 contract adjustment and sends this amount in the 005010X221A1 transaction as a CO-45 CARC code. The $700.00 is deducted from the $1200.00 patient responsibility from the primary group purchaser's consideration, leaving $500.00. The secondary group purchaser pays $450.00 on the claim, leaving $50.00 as patient responsibility (PR).

CLP*id*2*2500*450*50*…
SVC*HC:proc*2500*450*…
CAS*OA*23*1300~
CAS*PR*3*50~
CAS*CO*45*700~
AMT*B6*1800~

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5.4 Appendix D: Prepaid Medical Assistance Program (PMAP) Program Codes for Medicaid Remittances

Group purchasers that report Medicaid claims in the 835 electronic remittance include the two-digit PMAP code with the claim. This code is used by providers when reporting encounters to the state.

Link to table of major program codes at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#P23_1322.

Use the loop 2100 Class of Contract REF segment to report the applicable PMAP code for the patient. Use the following format:

REF*CE*PMAP XX~ where XX is the PMAP code.

(Use capital letters PMAP, followed by a space, followed by the 2-character PMAP code).

Note: Only one REF*CE segment is allowed per claim. Do not use the REF*CE segment to report the PMAP code if a REF*CE segment is already used to report other Class of Contract information for a claim.

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5.5 Appendix E: Reporting All Patients Refined Diagnosis Related Groups (APR-DRG)

Follow the general guidelines in the X12 "RFI # 2166: Reporting APR-DRG on 5010 835" on the X12 website or as otherwise maintained by X12 and the instructions and examples below. Note: At the time of publication of this rule, the X12 response to RFI #2166 was located at http://rfi.x12.org/Request/Details/2166?stateViewModel=WPC.RFI.Models.ViewModels.RequestViewModel.

Instructions:

In the 2100 Loop, Other Claim Related Identification, set REF01 to CE ("class of contract"). In REF02, list the applicable class of contract (such as a program or product name), followed by 5 spaces and then the abbreviation "APRDRG=" and then the applicable APRDRG number.

Examples:

The examples below were submitted by the Minnesota Department of Human Services (DHS). The first example shows the reporting of the APR-DRG along with the PMAP code. The second example shows just the reporting of the PMAP code. Other group purchasers may substitute their own "class of contract code" designation (such as the applicable product name or other contract category) for "PMAP MA" shown below.

Example for payers reporting both the PMAP code and the APR-DRG

CLP*CR19394TEST2*2*23346.99*0**MC*21628000400000000*11*0**159
CAS*CO*A1*23346.99
NM1*QC*1*DOE*JOHN****MR*99999999
MIA*0****MA32**************M53*MA33
REF*CE*PMAP MA APRDRG=54011
REF*1L*U
REF*EA*0853682
DTM*232*20150731
DTM*233*20150801
DTM*050*20161006
AMT*AU*11235.78

[Note: The information in red type – the class of contract code and APR-DRG number -- cannot exceed 50 characters].

5 spaces between the PMAP code information and the APR-DRG information.

Example for payers reporting the PMAP code only (non-inpatient claim or payer is not using the APR-DRG payment methodology)

CLP*CR19394TEST2*2*23346.99*0**MC*21628000400000000*11*0**159

CAS*CO*A1*23346.99

NM1*QC*1*DOE*JOHN****MR*99999999

MIA*0****MA32**************M53*MA33

REF*CE*PMAP MA

REF*1L*U

REF*EA*0853682

DTM*232*20150731

DTM*233*20150801

DTM*050*20161006

AMT*AU*11235.78