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## Best Practice Recommendation for

*Standard Coding of Denials and Adjustments  
in the HIPAA 835 Remittance Advice  
Transaction  
(835 v4010A1 & 5010)*

For use with:  
ASC X12N 835 (004010X092A1)  
ASC X12N 835 (005010X222)  
Health Care Claim: Payment/Advice

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**Best Practice Recommendation (BPR)**  
**for Standard Coding of Denials and Adjustments in the HIPAA 835 Transaction**

- Topic:** Electronic Processing of the 835 Remittance Advice Transaction
- Goal:** Automated posting of the 835 Remittance Advice Transaction by provider organizations
- Summary:** This Best Practice recommends the specific HIPAA codes to be used by health plans when adjusting/denying a claim for a specific set of business reasons.
- Applicability:** The table located at <http://www.onehealthport.com/worksmart/wsadoptionmatrix.php> identifies participating health plans and provider organizations. i.e. those that have endorsed and implemented these best practices.
- All providers and health plans are encouraged to follow these Recommended Best Practices.

This BPR Document is intended to accompany the 4010A1 Implementation Guide & 5010 TR3 for the ASC X12N Health Care Claim Payment/Advice: 835 transactions. Complete versions of these documents can be purchased at <http://store.x12.org/>

The HIPAA mandated Implementation Guide and TR3 for the 835 transaction specify the complete set of requirements that must be met when creating and sending an 835RA transaction. The objective of this BPR document is limited to recommending HIPAA codes to be used for conveying the business reason that explains why a claim was adjusted/denied.

## **Overview & Intent of this BPR Document**

Health plans use the 835 Remittance Advice (RA) transaction to convey to provider organizations information about how their claim(s) was processed. In cases where payment of a claim is adjusted or denied, health plans use standard HIPAA group codes, reason codes and sometimes remark codes to convey the business reason for the adjustment/denial. With the myriad HIPAA denial and adjustment codes from which to choose, health plans may use different codes to deny/adjust a claim, even though the denial/adjustment was for the same business reason. Use of different HIPAA codes for the same business reason makes automated posting of the 835RA problematic for the provider organizations. In many cases, their staff needs to manually review the codes that were received in order to infer the business reason for the adjustment/denial that was intended by the particular health plan. By eliminating the need for manual review, staffing efficiencies and expedited posting are possible.

The WorkSMART Institute's Business & Technology Workgroup identified problematic situations for provider organizations where health plans use different HIPAA codes on the 835RA for the same denial/adjustment reason. This Best Practice recommends the specific HIPAA codes to be used by health plans when adjusting/denying a claim for those business reasons.

The document does not address all possible business reasons or all HIPAA codes. Rather, it focuses on those adjustment/denial business reasons where wide variation in the use of HIPAA codes by health plans exists and that variation creates problematic situations for providers. The intent of the document is to clearly convey which HIPAA codes should be associated with each of the adjustment/denial business reasons.

## Best Practice Coding Recommendations

To reduce unnecessary variation on 835RA's received by provider organizations, health plans are encouraged to use the recommended HIPAA Group Codes, Reason Codes and Remark Code outlined below when adjusting/denying claims for the specified business reasons.

This document assumes that all coding conventions outlined in X12N 835 TR3 will be followed. This includes, but is not limited to, the use of :

- Valid Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Codes (CARC)
- A Remittance Advice Remark Code (RARC) along with a Claims Adjustment Reason Code (CARC) where and as required by X12. Reason Codes that require a Remark Code include, but are not limited to 16, 96,125,148,226,227, A1, D23.

### I. **Overview:** Business Reasons and Recommended HIPAA Reason Codes

The following lists three common business reasons for adjusting/denying a claim. The table below each business reason contains recommended Claim Adjustment Reason Codes and the business condition under which they should be used.

#### A. *Business Reason 1: Provided information had invalid or missing information*

HIPAA CARC	Business Usage
16	Used when information <i>in addition to that which is contained in the 837 claim</i> , is needed for adjudication. In other words, an attachment or other form of documentation needs to be submitted to the health plan.
125	Used when <i>information on the 837 is missing or is incorrect</i> , and that information is required for adjudication. No attachment needs to be submitted to the health plan.

**B. Business Reason 2: The billed service is not covered**

HIPAA CARC	Business Usage
96	Used when the <i>billed service is not a covered charge</i> per the member or provider contract.
Others as listed below	Other more specific reasons why a billed service would not be covered, e.g. not medically necessary, pre-existing condition, no pre-auth obtained, etc.

**C. Business Reason 3: The benefit for the billed service is not separately payable**

HIPAA CARC	Business Usage
97	Used when the <i>benefit for this service is included in the payment/allowance</i> for another service/procedure that has already been adjudicated.

**II. Detail:** Business Reasons and Recommended HIPAA Group Codes, Reason Codes and Remark Codes

For each of the above Business Reason and its associated HIPAA Claim Adjustment Reason Codes (CARC), the table contains recommended HIPAA Group Code, Remittance Advice Remark Code (RARC) and the business conditions under which they should be used.

Legend: In the Group Code column of all of the tables:

- CO/PI - indicates that a 'CO' will be used if a contract is in place and a 'PI' will be used if a contract is not in place
- CO/PI - used in cases where information should be supplied by the provider, and the patient cannot be billed for the balance.
- PR - used in cases where the provider is non-Par, and the patient can be billed for the balance.

Note: A Group Code of 'CR' can be used with any HIPAA Claim Adjustment Reason Code in situations related to a payment/adjustment reversal

**A. Business Reason 1: Provided information had invalid or missing information**

16 - Used when information *in addition to that which is contained in the 837 claim*, is needed for adjudication. In other words, an attachment or other form of documentation needs to be submitted to the health plan.

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
CO/PI or PR	16	M23	<i>Invoice</i> is missing
CO/PI or PR	16	M30	<i>Laboratory/Pathology Report</i> is missing
CO/PI or PR	16	M31	<i>Radiology Report</i> is missing
CO/PI or PR	16	M69	<i>Documentation</i> needed to support modified procedure code is missing
CO/PI or PR	16	N4	<i>EOB</i> from prior payer is missing
CO/PI or PR	16	N26	<i>Itemized Bill</i> is missing
CO/PI or PR	16	N29	<i>Medical documentation</i> is missing
CO/PI or PR	16	N350	<i>Description</i> required for an unlisted procedure
CO/PI or PR	16	N206	<i>Supporting documentation does not match</i> the claim. (Frequently used when EOB from prior payer does not match submitted claim)

125 - Used when *information on the 837 is missing or is incorrect*, and that information is required for adjudication. No attachment needs to be submitted to the health plan.

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
CO/PI or PR	125	M20	The <i>HCPC Code</i> is not appropriate to the service that was billed
CO/PI or PR	125	M44	The <i>Condition Code</i> that was used is missing or not appropriate
CO/PI or PR	125	M50	The <i>Revenue Code</i> that was used is missing or not appropriate
CO/PI or PR	125	M51	The <i>Procedure Code</i> that was used is missing or not appropriate
CO/PI or PR	125	M53	The <i>Days or Units of Service</i> that were used is missing or not appropriate
CO/PI or PR	125	MA30	The <i>Type of Bill</i> (data field) was invalid
CO/PI or PR	125	N34	The <i>Claim Form</i> used was incorrect for this service
CO/PI or PR	125	N77	The <i>Provider Number</i> is missing
CO/PI or PR	125	M119	The <i>National Drug Code (NDC)</i> is missing

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
			or invalid
CO/PI or PR	125	N4	Other payer's <i>Explanation of Payment information</i> is missing or invalid
CO/PI or PR	125	N207	The <i>Weight</i> is missing or invalid
CO/PI or PR	125	N209	The <i>Taxpayer Identification Number (TIN)</i> is missing or invalid
CO/PI or PR	125	N350	<i>Description</i> required for an unlisted procedure

The following business reasons are often **miscoded** as CARC 16 or 125. These business conditions **do not fall** under Business Reason #1 and should be coded appropriately as recommended below.

Business Reason for claim adjustment or denial	Group Code	CARC	RARC
The procedure code is inconsistent with the modifier used or a required modifier is missing (To be used when indicating that service is not eligible for payment in accord with MPFSDB indicator)	CO/PI	4	
Payment adjusted because this care may be covered by another payer per coordination of benefits.	CO/PI	22	N4
Patient payment option/election not in effect. (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.)	CO/PI or PR	106	
The disposition of this claim/service is pending further review	CO/PI or PR	133	
Payment is denied when performed/billed by this type of provider in this type of facility	CO/PI or PR	171	
Services not documented in patients' medical records	CO/PI	B12	
Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	CO/PI or PR	B15	

**B. Business Reason 2: The billed service is not covered**

96 - Used when the *billed service is not a covered charge* per the member or provider contract.

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
PR	96	N216	<i>Not a covered benefit for this patient</i>

Reason Code 96 should only be used as a general business reason when the billed service is denied because it is not a covered charge per the member or provider contract.

Whenever possible, the following Reason Codes, other than 96, should be used to provide more specificity.

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
PR	20		Claim denied because this injury/illness is covered by the liability carrier
PR	33		Claim denied. Insured has no dependent coverage
PR	38		Services not provided or authorized by designated (network/primary care) providers
CO/PI or PR	45		Charges exceed contracted/ legislated fee arrangement.
PR	49		These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
CO/PI or PR	50		These are non-covered services because this is not deemed a 'medical necessity' by the payer
PR	51		These are non-covered services because this is a pre-existing condition
CO/PI, or PR	117		Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
PR	119		Benefit maximum for this time period or occurrence has been reached.
PR	158		Payment denied/reduced because the service/procedure was provided outside of the United States.
PR	160		Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
CO/PI	167		This (these) diagnosis(es) is (are) not covered.
CO/PI, PR	170		Payment is denied when performed/billed by this type of provider
CO/PI	171		Service cannot be provided by this type of provider in this type of facility
CO/PI	B12		Services not documented in patients' medical records
CO/PI	B14		Payment denied because only one visit or consultation per physician per day is covered

**C. Business Reason 3: The benefit for the billed service is not separately payable**

- 97 - Used when the *benefit for this service is included in the payment/allowance* for another service/procedure that has already been adjudicated.

Group Code	CARC	RARC	Business Condition for claim adjustment or denial
CO/PI	97	M15	<i>Separately billed services/tests have been bundled</i> as they are considered components of the same procedure. Separate payment is not allowed (To be used for Component Procedures and those within a Global Package)
CO/PI	97	N525	<i>Procedure not separately payable within the global period of another service</i>
CO/PI	97	M80	<i>Not covered when performed during the same session/date</i> as a previously processed service for the patient
CO/PI	97	N19	<i>Procedure code incidental</i> to primary procedure (To be used when indicating that Status B services is not eligible for payment)

# Appendix

- **Recommended HIPAA Coding Sorted by Type of Business Reason**
- **Recommended Evaluation and Use Order for HIPAA Group Codes**

**Recommended HIPAA Coding Sorted by Type of Business Reason**

The following list is a compilation of all HIPAA codes identified above and is sorted by Type of Business Reason for adjustment or denial.

<b>Business Reasons for adjustment or denial</b>		<b>HIPAA Coding</b>		
<b>Type</b>	<b>Business Usage</b>	<b>Group Code</b>	<b>CARC</b>	<b>RARC</b>
Authorization	Services not provided or authorized by designated (network/primary care) providers	PR	38	
Benefit - Dependent	Claim denied. Insured has no dependent coverage	PR	33	
Benefit - Maximum	Benefit maximum for this time period or occurrence has been reached.	PR	119	
Benefit – Medical Necessity	These are non-covered services because this is not deemed a `medical necessity' by the payer	PR	50	
Benefit – Not Covered	Not covered by patient's plan	PR	96	N216
Benefit - Routine/ Preventive care	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	PR	49	
Billing Error - Bundling/ UnBundling	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed (To be used for Component Procedures and those within a Global Package)	CO/PI or PR	97	M15
Billing Error - Bundling/ UnBundling	Procedure not separately payable within the global period of another service.	CO/PI or PR	97	N525
Billing Error - Bundling/ UnBundling	Not covered when performed during the same session/date as a previously processed service for the patient	CO/PI or PR	97	M80
Billing Error - Bundling/ UnBundling	Procedure code incidental to primary procedure (To be used when indicating that Status B services is not eligible for payment)	CO/PI or PR	97	N19
Billing Error – Coding Doesn't Match	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO/PI	4	
Billing Error - Missing/ HCPC Code	HCPC Code	CO/PI	125	M20

<b>Business Reasons for adjustment or denial</b>		<b>HIPAA Coding</b>		
Invalid/ Inappropriate Data Element		or PR		
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Condition Code	CO/PI or PR	125	M44
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Revenue Code	CO/PI or PR	125	M50
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Procedure Code	CO/PI or PR	125	M51
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Days or Units of Service	CO/PI or PR	125	M53
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Type of Bill (data field)	CO/PI or PR	125	MA30
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Explanation of Payment	CO/PI or PR	125	N4
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Claim Form	CO/PI or PR	125	N34
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Provider Number (usually refers to the Medicare or Medicaid provider number)	CO/PI or PR	125	N77
Billing Error - Missing/ Invalid/ Inappropriate Data Element	National Drug Code (NDC)	CO/PI or PR	125	M119
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Weight	CO/PI or PR	125	N207
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Taxpayer Identification Number (TIN)	CO/PI or PR	125	N209
Billing Error - Missing/ Invalid/ Inappropriate Data Element	Description	CO/PI or PR	125	N350
Billing Error – Multiple exams	Payment denied because only one visit or consultation per physician per day is covered	CO/PI	B14	
Billing Error – Provider /	Payment is denied when	CO/PI	170	

<b>Business Reasons for adjustment or denial</b>		<b>HIPAA Coding</b>		
Facility	performed/billed by this type of provider	or PR		
Billing Error – Provider / Facility	Payment is denied when performed/ billed by this type of provider in this type of facility	CO/PI or PR	171	
COB	Payment adjusted because this care may be covered by another payer per coordination of benefits.	CO/PI	22	N4
Contract - Charges	Charges exceed contracted/ legislated fee arrangement.	CO/PI or PR	45	
Contract - Diagnosis	This (these) diagnosis(es) is (are) not covered.	CO/PI	167	
Documentation - Doesn't Match	EOB doesn't match claim	CO/PI or PR	16	N206
Documentation - Missing	Invoice	CO/PI or PR	16	M23
Documentation - Missing	Laboratory/Pathology Report	CO/PI or PR	16	M30
Documentation - Missing	Radiology Report	CO/PI or PR	16	M31
Documentation - Missing	Support for Modifier	CO/PI or PR	16	M69
Documentation - Missing	EOB from other payer	CO/PI or PR	16	N4
Documentation - Missing	Itemized Bill	CO/PI or PR	16	N26
Documentation - Missing	Medical Documentation	CO/PI or PR	16	N29
Documentation - Missing	Description of unlisted procedure	CO/PI or PR	16	N350
Documentation – Not in Chart	Services not documented in patients' medical records	CO/PI	B12	
Eligibility	Patient payment option/election not in effect. (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.)	CO/PI or PR	106	
Injury/accident/illness	Claim denied because this injury/illness is covered by the liability carrier	PR	20	
Injury/accident/illness	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion	PR	160	

<b>Business Reasons for adjustment or denial</b>		<b>HIPAA Coding</b>		
Pre-existing conditions	These are non-covered services because this is a pre-existing condition	PR	51	
Review Decision	Decision may be reviewed if contract or plan benefit documentation is received	CO/PI or PR	17	N358
Review Decision	Claim will be reopened if requested documentation is received within one year from date of denial	CO/PI	17	N366
Review Decision	The disposition of this claim/service is pending further review	CO/PI or PR	133	
Service Location	Payment denied/reduced because the service/procedure was provided outside of the United States.	PR	158	
Transportation	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	CO/PI or PR	117	

## Recommended Evaluation and Use Order for HIPAA Group Codes<sup>\*1</sup>

Group Codes are primarily used to identify who is responsible for the adjusted balance of a billed charge that is not paid by the insurance company.

The recommended order for evaluating which Group Code to use is:

1. If the adjusted amount is the patient's responsibility . . .

Use code PR - Patient Responsibility.

This group code must be used when the adjustment represents an amount that is the responsibility of the patient. Typical examples include, but are not limited to, lack of eligibility, deductibles, copay and coinsurance.

2. If the adjusted amount is not the patient's responsibility AND there is a contract between the health plan and provider that addresses the adjustment OR there is a regulatory requirement that addresses the adjustment . . .

Use code CO - Contractual Obligation.

This group code must be used when there is an adjustment to a submitted charge AND that adjustment is covered by:

- a contractual agreement, or a Letter of Agreement (LOA), between the payer and provider, OR
- a relevant regulatory requirement

Generally, these adjustments are considered write offs for the provider and are not billed to the patient.

If there is no contract or LOA, then a 'PI' Group Code should be used.

3. If the adjusted amount is not the patient's responsibility AND there is not a contract between the health plan and provider . . .

Use code PI - Payer Initiated.

This group code must be used when there is an adjustment to a submitted charge AND there is NO contractual agreement or Letter or Understanding (LOA) between the payer and provider and NO relevant regulatory requirement.

In the opinion of the payer, the adjustment is not the responsibility of the patient. The provider will need to determine whether these are adjustments that must be written

off or can be billed to the patient.

4. If the adjusted amount is a reversal of a previously reported claim or claim payment . . .

Use code CR - Correction and Reversals.

This group code must be used for the reversal of a previous payment on a claim that has already been processed. When correcting a prior claim, CLP02 (claim status code) needs to be 22 and CAS01 must be 'CR'. See ASC X12N Health Care Claim Payment/Advice Implementation Guide (835) section 2.2.8 for complete information about corrections and reversals.

5. If no other category is appropriate . . .

Use code OA - Other Adjustment

This group code must be used when no other group code applies to the adjustment. Typical examples include, but are not limited to, Coordination of Benefit and Medicare Supplemental Balances.

Avoid use of the Other Adjustment Group Code (OA) whenever possible.

<sup>\*1</sup> Reference:

This material is extracted from the following documents:

- For the 4010A1 version - Section 2.2.4 of the front matter of the 835 Implementation Guide
- For the 5010 version - Section 1.10.2.4 of the front matter of the 835 TR3