Explanatory Code List

As Of

01 October 2006

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SPECIAL PROCESSING CODES

INFRC RECOVERED FROM INCOMING FUND.

This amount was deducted from the funds you have previously sent to Alberta Health. These funds may be a premium or claim payment.

RTRF REASSESS TRANSACTION REFUSED

Your reassess transaction was reviewed, and did not result in a change to the original payment and therefore has been refused.

RVRSL Reversal

This is a reversal to a previously assessed item.

PATIENT REGISTRATION

01 NOT REGISTERED

We have no record of this person registered with this Personal Health Number.

01A NOT REGISTERED

This person is not registered under the Alberta Health Care Insurance Plan. If the patient is a newborn, submit a new claim with a person data segment and the appropriate newborn code.

01B NON RESIDENT

We cannot confirm that this patient is a resident of Alberta. Please contact the patient to obtain the correct billing information.

01C GOOD FAITH CLAIM

Payment has been refused as:

a) A Good Faith claim was previously paid for this patient; therefore, this patient does not qualify for further Good Faith claim processing, or

b) Good Faith claims are not payable for visitors to Alberta or for residents covered by the federal government, such as RCMP, Canadian Forces members or inmates in federal corrections facilities.

Refer to the practitioner resource guide for information regarding your billing alternatives.

02 REGISTRATION NUMBER/PHN CONFLICT

The Health Registration Number and the Personal Health Number (PHN) used are not for the same person.

03 NEWBORN

The claim was refused as the Plan is unable to contact the parent(s) of this child to confirm registration.

04 DONOR'S REGISTRATION NUMBER USED

Submit this claim using the Personal Health Number of the donor recipient.

04A CHANGED PERSONAL HEALTH NUMBER

This is the correct Personal Health Number for this patient. All new claims for this patient should be submitted with this number.

05 PATIENT PERSONAL HEALTH NUMBER - NOT EFFECTIVE

This Personal Health Number is not effective for the date(s) of service.

PATIENT REGISTRATION (cont'd)

05A INVALID PERSONAL HEALTH NUMBER

The Personal Health Number is invalid or blank.

05AA OPTED OUT RESIDENTS

The patient has opted out of the Alberta Health Care Insurance Plan. The patient has agreed to assume financial liability for all health services. Please contact your patient regarding payment for your services.

05B UNREGISTERED WCB CLAIM

The patient is not eligible for Alberta Health Care coverage for the date(s) of service. Submit your claim directly to the Workers' Compensation Board.

05BA INVALID/BLANK REGISTRATION NUMBER

This claim has been refused as the registration number is:
(a) blank
(b) invalid

05BB INVALID/BLANK ULI

This claim has been refused as the Unique Lifetime Identifier is:
(a) blank
(b) invalid
(c) not a valid ULI for the Service Recipient

05C ELIGIBILITY EXTENDED HEALTH BENEFITS PROGRAM

The patient did not have coverage under the Extended Health Benefit (EHB) program on this date.

Effective April 1,2002, to be eligible for EHB the patient must be a recipient of the Alberta Widows' Pension or their dependant.

If your patient does not fit this description, benefits will be refused. If the patient needs more information, contact Customer service and Registration Branch at (780)427-1432.

05E E.H.B. COVERAGE

Payment has been refused as the service(s) were provided when the patient did not have coverage under the Extended Health Benefits Program.

06 RETROACTIVE ELIGIBILITY CHANGE

Your request to change or reassess this claim was refused. Due to a retroactive eligibility change, the patient is not eligible for Alberta Health Care coverage for this date of service.

PATIENT REGISTRATION (cont'd)

07 NEW RECIPIENT FOR ALTERNATIVE PAYMENT PLAN CONTRACT

Your claim for a new recipient was paid as a fee for service benefit.

08 NEW RECIPIENT PREVIOUSLY PAID FOR APP CONTRACT

Payment was refused as a fee for service claim was previously paid for a new recipient.

09 INITIAL ROSTER RELATIONSHIP

Payment was refused as an Initial Roster relationship exists for this patient. Therefore, a fee for service claim is not payable under a Temporary Roster relationship.

PRACTITIONER REGISTRATION (cont'd)

10 INELIGIBLE PRACTITIONER/INCORRECT SUBMISSION

We have not received notification from the Governing Body/Licensing Association that the Practitioner is accredited to perform this service.

10A SERVICE PROVIDER RESTRICTIONS

Our records indicate that the Service Provider is:

(a) restricted to a specific Facility or
(b) restricted to performing specific services.

10AA INELIGIBLE PRACTITIONER

This claim has been refused as you are not entitled to payment for this type of service.

11 LOCUM BUSINESS ARRANGEMENT

This claim has been refused as the Business Arrangement does not include a Business Arrangement Type of Locum.

INELIGIBLE SERVICES

20 INELIGIBLE SERVICES

Payment was refused as the services are not covered in the Schedule of Benefits. The services include:

Advice by Telephone
Ambulance Service
Anaesthetic Materials
Cosmetic Services
Drugs/Agents
Medical and Surgical Appliances and Supplies
Medical Testimony in Court
Oculo-visual/Optometric services for residents age 19 through 64 years (For dates of service on or after December 1, 1994)
Secretarial or Reporting Fees
Stand by Time
Tinted Glasses (EHB)
Travel Time
Refer to the General Rule 3 in the Schedule of Medical Benefits or General Rule 5.1 in the Schedule of Oral and Maxillofacial Surgery Benefits.

20A THIRD PARTY SERVICES

Examinations or services required to provide reports or certificates requested by a third party are not an insured service, eg:

- Adoption
- Attendance at Camp
- Autopsies
- Employment
- Insurance/disability
- Family & Social Services
- University or other school entrance
- Judicial Purposes (examinations/procedures requested by police)
- Motor Vehicle Licence (except after the age of 74.5 years of age)
- Participation in Sports
- Passport or Visa
- Immigration Requirements

20AB EXPERIMENTAL/RESEARCH SERVICES

Payment was refused as the Alberta Health Care Insurance Plan does not pay benefits for services that are experimental and/or in the research stage.

20B R.C.M.P., ARMED FORCES AND FEDERAL PENITENTIARY

Members of the RCMP, Armed Services and inmates of a Federal Penitentiary are not beneficiaries under the Plan.

20C PRACTITIONER BILLING FOR OWN FAMILY

Services provided to members of your family or yourself are not a benefit under the Plan.

INELIGIBLE SERVICES (cont'd)

20D DENTAL CARE - ORAL SURGERY

This service is not an oral surgical procedure payable by the Plan.

20E BENEFIT GUIDE

This is an incorrect Health Service Code. Please refer to the Plan's appropriate fee schedule.

20F EXCLUDED ITEM

This service is not payable under the Extended Health Benefits Program.

21 WORKERS' COMPENSATION BOARD CLAIM

This claim is the responsibility of the Workers' Compensation Board.

21A PAYMENT RESPONSIBILITY/BENEFIT CODE

The payment responsibility (Workers' Compensation Board or Alberta Health Care) and Health Service Code submitted do not agree. Verify the responsibility and submit a new claim.

21AA WORKERS' COMPENSATION BOARD - PATIENT OVER 14 YEARS

The patient must be 14 years of age or older to qualify for a Workers' Compensation Board claim.

21AB WORKERS' COMPENSATION BOARD CLAIM SUBMISSIONS

Payment was refused as effective June 1, 2000 Workers' Compensation Board claims are to be submitted directly to the Workers' Compensation Board.

21B WORKERS' COMPENSATION BOARD (OUT OF PROVINCE)

This claim is the responsibility of another Province's Workers' Compensation Board. Please submit the claim directly to the appropriate Workers' Compensation Board.

22 INELIGIBLE PATIENT

Our records indicate this claim is the responsibility of another Provincial Medical Plan.

23 CONTRACT SERVICES

This service is payable only to practitioners who provide medical services under a written agreement with the Department of Health.

INELIGIBLE SERVICES (cont'd)

23A PRIOR APPROVAL

Payment was refused as:

(a) this service requires prior approval from the patient's Provincial Medical Plan and/or
(b) prior approval was not received for this date of service.

24A PODIATRY SERVICES ONLY PAYABLE IN OFFICE FACILITY

This service is only payable when performed in an office.

25 EXCLUDED SERVICE - RECIPROCAL PROGRAMS

Payment has been refused as this service is excluded according to the Reciprocal Agreement. Your claim should be billed directly to the patient or, if applicable, their home provincial health plan.

25A MEDICAL RECIPROCAL - INCORRECT CLAIM

Payment was refused as you have submitted a Medical Reciprocal claim for services provided to an Alberta patient.

28 OPTED OUT PRACTITIONER

This service was provided by a Practitioner who has opted out of the Alberta Health Care Insurance Plan and there is no indication that this was an emergency service.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED

Person Data Segment

30 ADDRESS

This claim was refused as the Address on the Person Data Segment is invalid, incomplete or blank.

30A PROVINCE CODE

This claim was refused as the Province Code on the Person Data Segment is invalid, incomplete or blank.

30AA CITY NAME

This claim was refused as the City Name on the Person Data Segment is invalid, incomplete or blank.

30AB COUNTRY CODE

This claim was refused as the Country Code on the Person Data Segment is invalid, incomplete or blank.

30AC POSTAL CODE

This claim was refused as the Postal Code on the Person Data Segment is invalid.

30B DATE OF BIRTH

This claim was refused as the Date of Birth on the Person Data Segment is:

(a) blank
(b) invalid
(c) incomplete
(d) after the date of service

30BA GENDER

This claim was refused as the Gender on the Person Data Segment is invalid or blank.

30E SURNAME

This claim was refused as the Surname on the Person Data Segment is invalid or blank.

30EA FIRST NAME

This claim was refused as the First Name on the Person Data Segment is invalid or blank.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Person Data Segment (cont'd)

30EB MIDDLE NAME

This claim was refused as the Middle Name on the Person Data Segment is invalid or blank.

30F PERSON TYPE

This claim was refused as the Person Type on the Person Data Segment is invalid or blank.

30G GUARDIAN/PARENT PERSONAL HEALTH NUMBER

This claim was refused as the Guardian/Parent Personal Health Number on the Person Data Segment is invalid or blank.

30H GUARDIAN/PARENT HEALTH PLAN NUMBER

This claim was refused as the Guardian/Parent Health Plan Number on the Person Data Segment is invalid or blank.

31 INCOMPLETE PERSON DATA

This claim has been refused as the Person Data Segment is:

(a) required
(b) incomplete for the Person Type submitted
(c) required as we have no record of the Personal Health Number which was submitted.

31A PERSON DATA SEGMENT CONFLICT

The Out of Province registration number and the Person Data Segment do not match the service recipient information in our files.

Confirm the patient's Out of Province health care card registration number, home province/recovery code, and personal data information with the patient or the patient's home provincial health plan. If applicable, submit a new claim with supporting text indicating that the physician has verified the patient's personal information.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Batch Process

34AA CLAIM CURRENT YEAR SEGMENT

The current year indicated within the claim number is not numeric or not the current year.

34AB CLAIM SEQUENCE NUMBER

The claim sequence number indicated within the claim number is not numeric.

34AC CLAIM CHECK DIGIT

The check digit number indicated within the claim number is invalid.

34AD ACTION CODE

The action code is inconsistent with other information segments within this transaction.

34B EMSAF INDICATOR

The EMSAF (Extraordinary Medical Services Assessment Fund) indicator is invalid.

34C CLAIM RECORD TYPE

The record type is invalid. To process the claim the record type must be:

(a) number 2 in the (batch header) data field
(b) number 3 in the (claim detailed record) field
(c) number 4 in the (batch trailer) data field

Refer to the Electronic Claims Submissions Specifications Handbook.

34DA CLAIM TRANSACTION TYPE

The transaction type is not CIPI.

Refer to the Electronic Claims Submissions Specifications Handbook.

34DB CLAIM SEGMENT TYPE

The segment type must be:

(a) CIBI - claim regular or
(b) CPDI - person data segment or
(c) CSTI - text segment or
(d) CTXI - text cross reference segment or
(e) in proper order

Refer to the Electronic Claims Submissions Specifications Handbook.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Batch Process (cont'd)

34DC SEGMENT SEQUENCE NUMBER

The segment sequence number is not incremental.

Refer to the Electronic Claims Submissions Specifications Handbook.

34DD CST1 SEGMENT REQUIRED

At least one CST1 segment must be submitted with an "R" (Reassess Action Code) transaction.

Refer to the Electronic Claims Submissions Specifications Handbook.

34DE MAXIMUM CST1 SEGMENT

The maximum number of CST1 segments (500) was exceeded.

34DF CIB1 SEGMENT REQUIRED

Only provide a "CIB1" Base Claim Segment when submitting a "D" (Delete Action Code) transaction.

34DG CPD1 SEGMENT NOT ALLOWED

A "CPD1" Person Data Segment cannot be provided when submitting an "R" (Reassess Action Code) transaction.

34DH MAXIMUM CPD1 SEGMENT

A transaction cannot have more than one "CPD1" Person Data Segment for any one person data type.

34EA CLAIM TEXT SEGMENT

The text information you supplied is not in alpha numeric format.

34EB CLAIM SOURCE CODE

The claim source code is invalid.

Refer to the Electronic Claims Submissions Specifications Handbook.

34EC SUPPORTING TEXT CROSS REFERENCE

The supporting text cross reference segment claim(s) number has failed the claim check algorithm.

Refer to the Electronic Claims Submissions Specifications Handbook.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Batch Process (cont'd)

34ED CTX1 AND CST1 SEGMENT

The transaction being cross referenced and referred by a "CTX1" Text Cross Reference Segment must have a "CST1" Text Segment.

34F CHART NUMBER

The chart number information was not in alpha numeric characters. Only ASCII print characters are valid for this field.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment

35 ACTION CODE

This transaction was refused as:

(a) the action code is invalid or
(b) Action code "R" (Reassess) is only allowed if text is submitted and the original Health Service Code which was reduced requires reassessment or
(c) Action code "D" (Delete) cannot be processed when the pay to code is not "BAPY" or
(d) Action code "C" (Change) cannot be processed on a refused claim.

35A INTERCEPT

The Intercept code on the claim is invalid.

35B RECOVERY CODE

The Recovery Code on the claim is invalid or not allowed for this Business Arrangement.

35C REASSESS REASON CODE

The Reassess Reason Code on the claim is invalid or blank.

35D CLAIM TYPE

The Claim Type on the claim is invalid or blank.

35E CONFIDENTIAL INDICATOR CODE

The Confidential Indicator Code on the claim is invalid.

35F CLAIM NUMBER

The Claim Number on the claim is invalid or blank.

35FA SUBMISSION OF A CLAIM NUMBER

The Claim Number submitted was previously used on a:

(a) refused claim or
(b) claim which is being held or
(c) paid service event or claim applied at a zero amount

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

35FB UNABLE TO PROCESS UPDATED TRANSACTION

The transaction to update a previously submitted claim cannot be processed as:

(a) the original add transaction cannot be located or
(b) the result of your original claim must be known or
(c) the original claim was previously deleted

35FC UNABLE TO PROCESS ADD TRANSACTION

This claim number submitted was previously used and the add "A" transaction cannot be processed. If applicable, submit the original claim number with the appropriate action code of "R" reassess, "C" change or "D" delete.

35G GOOD FAITH INDICATOR

The Good Faith Indicator on the claim is invalid.

35H SUPPORTING DOCUMENTATION INDICATOR

The Supporting Documentation Indicator on the claim is invalid.

35J TEXT INDICATOR

The Text Indicator on the claim is invalid.

35K PAY TO CODE

The Pay to Code on the claim is invalid or cannot be changed.

35KA PAY TO CODE/PAY TO ULI CONFLICT

There is a conflict between the information shown in the Pay to Code and the Pay to ULI fields. When the Pay to Code is "OTHR" (other) the Pay to ULI cannot be the:

(a) Service Provider or
(b) BA Payee or
(c) Patient or
(d) AH Registration contract holder responsible for the patient.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

35L PAY TO ULI

The Pay to ULI on the claim is invalid or blank.

35M NEWBORN CODE

The Newborn Code is invalid or not required when the patient's Personal Health Number is already provided on the claim.

36 LOCUM BUSINESS ARRANGEMENT

The Locum Business Arrangement number on the claim is invalid or not required.

36A LOCUM/BUSINESS ARRANGEMENT NUMBERS

The Locum Business Arrangement and the Business Arrangement fields were not completed properly. Please refer to the "Physician's Resource Guide" and submit a new claim.

37 BUSINESS ARRANGEMENT

The Business Arrangement number on the claim:

(a) is invalid or blank or
(b) is restricted to performing specific services or
(c) is restricted to performing services at a specific facility or
(d) is not registered with the Submitter of the transaction or
(e) does not have a relationship with the Service Provider PHN submitted
(f) is restricted to patients from a specific area.

37A PROVIDER ULI

The Service Provider ULI field is blank, invalid or not effective for the date of service submitted.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

37B SKILL CODE

The Skill Code on the claim is invalid or blank.

39 DATE OF SERVICE

The Date of Service for the claim is:

(a) invalid or blank or
(b) more than 1 year from Date of Birth (Newborn) or
(c) in conflict with the explicit modifier indicated

39A DATE OF SERVICE CONFLICT

The Date of Service for the claim and the Supporting Documentation do not agree.

39B HEALTH SERVICE CODE

Payment has been refused as the Health Service Code on the claim is:
(a) blank or invalid or
(b) not listed in the applicable Alberta Health Care Insurance Plan Schedule of Benefits

39BA GENDER RESTRICTION

The Health Service Code and/or diagnosis submitted does not agree with the gender of the patient.

39BB AGE RESTRICTION

The patient does not qualify for this service due to the age restriction.

39BC HEALTH SERVICE CODE NOT APPROPRIATE FOR DIAGNOSIS

The type of service provided does not agree with the diagnosis.

39BD DATE OF SERVICE/HEALTH SERVICE CODE DATE CONFLICT

The Health Service Code is not effective on this date of service.

39BE CONCEPTUAL AGE

Payment for the additonal benefit has been refused as the patient's conceptual age is greater than 26 weeks.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

39C NUMBER OF CALLS

This claim was refused as:

(a) the number of calls is invalid or blank or
(b) the number of calls on the claim is more than the number allowed for this service.

Submit applicable claims with text information.

39D LOCATION OF SERVICE

The Location of Service on the claim is not appropriate for the Health Service Code indicated.

39DA FACILITY NUMBER

The Facility Number on the claim is invalid or blank.

39DB FUNCTIONAL CENTER CODE

The Functional Center Code on the claim:

(a) is blank or invalid
(b) does not exist for the facility submitted
(c) is restricted from performing the service submitted

39DC ORIGINATING FACILITY NUMBER

The Collection Facility Number on the claim is invalid or blank.

39DD ORIGINATING LOCATION

The originating location on the claim is:

(a) invalid or blank
(b) not required when the Originating Facility Number is completed.

39DE ORIGINATING FACILITY NUMBER/LOCATION FOR PATHOLOGY SERVICES

The Originating Facility Number or the Originating Location Field is required for Pathology Services (E Codes).

39EB DIAGNOSTIC CODE

The Diagnostic Code on the claim is blank or invalid.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

39EC HEALTH SERVICE CODE AND DIAGNOSTIC CODE CONFLICT

The claim was refused as the health service code and the diagnostic code on the claim are in conflict.

39F USE CLAIMED AMOUNT INDICATOR

The "Use Claimed Amount Indicator" on the claim is invalid.

39FA AMOUNT CLAIMED/USE CLAIMED AMOUNT INDICATOR

Your claim was refused as:
(a) the amount claimed is blank. Claims for unlisted procedures (health service codes in the 99.09 series) require a claimed amount and a "Y" in the claimed amount indicator field or
(b) the amount claimed is blank or invalid and the claimed amount indicator is "Y" or
(c) the amount claimed is completed, but the claimed amount indicator is blank or invalid.

39G MODIFIER CODE

The Modifier Code field:

(a) is required with the service submitted
(b) is invalid
(c) can only have one modifier of the same type
(d) can not have this combination of modifiers.
(e) must have a valid two digit numeric suffix when modifier type is SURT

39H TELEHEALTH SERVICES

This claim was refused as the health service code and the modifier code are in conflict for the following reasons:

(a) "STFO" (store and forward modifier) applies only to teledermatology or
(b) "TELES" (telehealth modifier) applies only to consultations and non-referred visits 03.01C, 03.03A and 03.04A.

41 DOCUMENTATION INCOMPLETE/NOT RECEIVED

The Supporting Documentation for this claim was incomplete or not received.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

41B TIME/SITES - E.H.B.

Submit a new claim indicating the number of units, quadrants or sextants.

42 HOSPITAL ADMISSION/ORIGINATING ENCOUNTER DATE

The Hospital Admission/Original Date on the claim is invalid or blank.

43 OUT OF PROVINCE HEALTH PLAN NUMBER

The Out of Province Health Plan number on the claim is invalid or blank.

45 INVALID REFERRING PRACTITIONER NUMBER

The Referring Practitioner's Personal Health Number on the claim is:

(a) blank or invalid or
(b) not an intraspecialty or
(c) from a practitioner without the appropriate discipline or skill

45A OUT OF PROVINCE REFERRAL INDICATOR

The Out of Province Referral Indicator on the claim is invalid.

45AA REFERRAL ULI INVALID UNABLE TO RESOLVE

Your claim has been refused as the Referral ULI is invalid. Contact the referring practitioner for the correct ULI number.

45B ENCOUNTER NUMBER

The Encounter number on the claim is invalid.

47 SERVICE RECIPIENT PERSONAL HEALTH NUMBER (PHN)

This claim was refused as the Service Recipient PHN cannot be changed. Delete the original claim and submit a new claim with the correct Service Recipient PHN.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

Base Claim Segment (cont'd)

48 PROVIDER PERSONAL HEALTH NUMBER (PHN)

This claim was refused as the Provider PHN cannot be changed. Delete the original claim and submit a new claim with the correct Provider PHN.

49 BUSINESS ARRANGEMENT/LOCUM BUSINESS ARRANGEMENT NUMBER

This claim was refused as the Business Arrangement and/or Locum Business Arrangement number cannot be changed. Delete the original claim and submit a new claim with the correct Business Arrangement or Locum Business Arrangement number.

SURGICAL PROCEDURES

50 TWO PHYSICIANS - UNRELATED ABDOMINAL SURGICAL PROCEDURES

Payment was reduced to 75% of the fee as the full benefit for the major procedure was paid to the physician most responsible for the patient's care.

50A PROCEDURES INCLUDED IN THE MAJOR PROCEDURAL BENEFIT

Payment was refused as this service is included in the fee paid for the major procedure.

50AA DIAGNOSTIC PROCEDURES RELATING TO SURGERY

Payment was refused as the diagnostic procedure is included in the benefit paid for the surgical procedure when performed under the same anaesthetic.

50B REPEAT CLOSED REDUCTION - SAME PRACTITIONER

Payment was refused as a repeat closed reduction performed by the same practitioner is not payable.

50BA REPEAT CLOSED REDUCTION - DIFFERENT PRACTITIONER

Payment was reduced to 50% as a different practitioner has performed a repeat closed reduction for the same fracture or dislocation.

50BB CLOSED - OPEN REDUCTION - DIFFERENT PRACTITIONER

Payment was reduced to 50% as a different practitioner has performed an open reduction for the same fracture.

50BC CLOSED - OPEN REDUCTION - SAME PRACTITIONER

Payment was refused as a closed reduction is not payable when the same practitioner performs an open reduction for the same fracture under the same anaesthetic.

51 PRE - AND/OR POST-OPERATIVE CARE - TWO PRACTITIONERS

Payment was reduced or refused as another Practitioner was paid for pre-and/or post-operative care.

51A UNILATERAL - BILATERAL PROCEDURES

Payment was reduced as the fee does not increase when a bilateral procedure is performed.

51G SURGICAL ASSISTS

Payment was refused according to General 13, for one of the following reasons:

(a) a surgical assist fee is not payable for the procedure performed
(b) a surgical procedure was not claimed for this date of service or

SURGICAL PROCEDURES (cont'd)

(c) documentation was not submitted to support a claim involving unusual circumstances.

52 PROCEDURES - RESUBMISSION

Payment was refused as this service cannot be paid when an associated procedure was claimed within 90 days.

See the NOTE in the Schedule of Medical Benefits following the health service code claimed.

52A LACERATIONS

Payment was made according to the explanation following Health Service Code 98.22B.

52B SAME PHYSICIAN - TWO FUNCTIONS

Payment was refused as only one benefit can be paid when both surgical and anaesthetic services are performed by the same physician.

OBSTETRICS

53 OBSTETRICS AND GYNECOLOGY

Payment was refused as conservative surgery for endometriosis (item 81.29C) must be claimed in addition to item 66.83. Please refer to the Note in the Schedule under Health Service Code 81.29C.

53A CHORIONIC VILLUS SAMPLING

Payment was refused as benefits for Chorionic Villus Sampling are only payable when the service is provided in a hospital.

54 INCLUDED SERVICES

Payment was refused as the service(s) is included in the benefit paid for the delivery.

54A POST-NATAL MAXIMUM

Payment was refused as only one routine post-natal visit, per physician, is payable.

54B PRE-NATAL CARE

Payment was refused as:

(a) only one 03.04B may be claimed per pregnancy per physician.
(b) Health Service Code 03.04B may not be charged within 91 days of a major visit item.
(c) a 03.03B benefit may only be claimed for the pre-natal visits and may not be claimed for date of service following a delivery.

MINOR PROCEDURES

56 PROCEDURE - VISIT

Payment was refused as:

(a) only the greater of a minor procedure or office visit is payable when the services and diagnosis are related or
(b) only the greater of a consultation and minor procedure are payable on the same date of service or
(c) only the greater of a procedure and hospital visit are payable on the same date of service or
(d) multiple surgical procedures have been performed; refer to Governing Rules 6.9.1, 6.9.2, 6.9.3, 6.9.5. and 6.9.7 e)

56A MULTIPLE MINOR SURGICAL PROCEDURES

Payment was reduced to 75% as only the greater benefit is payable in full when multiple minor surgical procedures are performed.

56B VARICOSE VEINS INJECTIONS

Payment was refused as the maximum for the Benefit Year (July 1 to June 30) was paid.

The Schedule of Medical Benefits allows one initial 51.92A, three 51.92B's, six repeat 51.92A's and up to eighteen 51.92B services for each patient per Benefit Year.

56C TRAY SERVICES

Payment was reduced or refused according to Governing Rules 14.1, 14.2 and 14.3 in the Schedule of Medical Benefits.

56D FIBREGLASS CAST

a) Payment was reduced to the equivalent rate of an application of a cast health service code (07.53B or 07.53D) as the service was performed in a nursing home, general or auxiliary hospital or a facility which has a contract with a Regional Health Authority.
b) Payment was reduced by a rate equivalent to health service code 07.53B or 07.53D as the benefit for the application of a cast is included in the fracture reduction health service code.
c) Payment was reduced by a rate equivalent to a major tray service benefit which was paid for health service code 07.53B or 07.53D as cast supplies are included in the benefits for 07.53H and 07.53J.

ANAESTHESIA

58 TWO PROCEDURES - TWO SURGEONS

Payment was reduced as the greater anaesthetic benefit is paid at 100% and the lesser at 75% when two procedures are performed consecutively by two surgeons under the same anaesthetic.

58A INCLUSIVE ANAESTHETIC BENEFIT

Payment was refused as pre-anaesthetic/post-anaesthetic visits are included in the anaesthetic benefit.

58B LOCAL ANAESTHETIC

Payment was refused as only the greater is payable when both the local anaesthetic and the procedure are claimed by the same practitioner.

58BA SIMULTANEOUS SURGERY

Payment was refused as only the greater anaesthetic benefit is payable when two practitioners operate simultaneously.

58C MULTIPLE BENIGN SKIN LESIONS

Payment was reduced or refused as only a single anaesthetic benefit is payable when surgical treatment of multiple benign skin lesions are performed under 45 minutes of anaesthetic.

58D RESUSCITATION

Payment was refused as Health Service Code 13.99E can only be paid when the physician is specially called for resuscitation. Submit a new claim using the appropriate Health Service Code 13.99J or 13.99F.

58E RELATED ANAESTHETIC CODE

Payment was made according to the information submitted on the Surgeon's claim.

58F ADDITIONAL AGE BENEFIT

Payment was reduced according to General Rule 12.7. Only one additional anaesthetic benefit per patient encounter is payable regardless of the number of services provided.

CONSULTATIONS/VISITS

60 INITIAL VISIT - MAJOR

Payment was refused as an initial visit provided by the same practitioner may not be claimed more than once every 180 days.

60A CONSULTATION - INCLUSIVE BENEFIT

Payment was refused as a consultation benefit is included in the payment for the procedure.

60AA CONSULTATION

Payment was reduced to the rate payable for a non-referred visit item as:

(a) the service does not meet the requirements of a consultation or
(b) the referral was not from a physician or
(c) the referral was from a family member

60B DENTAL CONSULTATION

Payment was refused as a dental consultation is only payable when it is requested by the patient's Physician, Dental Surgeon, or Oral and Maxillofacial Surgeon and it concerns a procedure payable under the Schedule of Oral and Maxillofacial Surgery Benefits.

60C HOSPITAL ADMISSION

Payment was refused as an admission is not payable when the patient was seen by the same Practitioner on the same day for the same or related diagnosis.

60E HOSPITAL VISIT - EMERGENCY AND OUTPATIENT DEPARTMENTS

Payment was refused as:

(a) another physician has claimed for the same service. Submit a new claim with a DSCH modifier according to Governing Rule 5.1 or
(b) 03.05F cannot be claimed by the same physician who provided the initial assessment prior to determining the disposition status of the patient.

60EA CRITICAL CARE - EMERGENCY VISIT

Payment was refused as the information/diagnostic code provided does not support payment under this Health Service Code. Submit a new claim with the appropriate emergency department visit.

GENERAL ASSESSMENT

Explanatory Codes 60EB to 61EA

60EB SERVICES UNSCHEDULED

Payment was refused as the maximum benefit for unscheduled services was reached.

60EC SPECIAL CALLBACKS TO HOSPITAL EMERGENCY OUT-PATIENT DEPARTMENT

Payment was refused according to General Rule 5.2 in the Schedule of Medical Benefits or General Rule 17 in the Schedule of Oral and Maxillofacial Surgery Benefits.

60ED MAXIMUMS FOR SPECIAL CALLBACKS AND SURCHARGES

Your claim was reduced in accordance with one of the Governing Rules 15.11.1 through 15.11.5 in the Schedule of Medical Benefits.

61 DRESSING CHANGES - BURNS

Your claim for 07.57B and 07.57A has been changed to an office visit as the service is not for a burn. The corresponding tray service has been deducted where applicable.

61A GENERALIZED DIAGNOSTIC CODES

Payment was refused as this service is included in the benefit paid for the related surgical procedure.

61B REMOVAL OF SUTURES

Payment was refused as the fee for removal of sutures is included in the surgical benefit according to General Rule 6.3 in the Schedule of Medical Benefits or General Rule 6.1 in the Schedule of Oral and Maxillofacial Surgery Benefits.

61C NURSING HOME AND SENIOR CITIZENS HOME

Payment was refused as the service was not provided in a "home" location as specified in Governing Rule 1.6.

61CA AUXILIARY HOSPITAL VISITS

Payment was reduced to a lesser benefit as the service provided was a routine visit for custodial care.

61CB AUXILIARY HOSPITAL/NURSING HOME VISIT/MANAGEMENT OF DIALYSIS PATIENTS

Payment was refused as a visit for a prior date of service during the same calendar week was paid.

GENERAL ASSESSMENT (cont'd)

61E CONCURRENT CARE

Payment was reduced or refused as services for concurrent care require supporting information according to General Rule 4.8 in the Schedule of Medical Benefits or General Rule 13 in the Schedule of Oral and Maxillofacial Surgery Benefits.

61EA CONTINUING CARE

Payment was reduced or refused according to General Rule 4.10 in the Schedule of Medical Benefits or General Rule 14 in the Schedule of Oral and Maxillofacial Surgery Benefits.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 61F to 63AA

61F CONFLICTING HOSPITAL DATES

Payment was reduced or refused as a benefit for some or all of the hospital dates of service was previously paid.

61G POST-PARTUM OFFICE VISITS

Payment was refused as this service is not payable when provided to a healthy newborn during the post-partum period.

61H INCLUSIVE - SURGICAL BENEFIT - PRE/POST-OPERATIVE CARE

Payment was refused as the service(s) for pre/post operative care is included in the surgical benefit.

62 PROFESSIONAL INTERVIEW/CASE CONFERENCE

Payment was refused as health service code 03.05YM may only be claimed when health service code 03.05Y has been previously submitted and paid. Please refer to the notes in the Schedule of Medical Benefits under health service codes 03.05Y and 03.05YM.

63 CLAIM IN PROCESS

Your claim is being held as:

(a) it requires manual assessment or
(b) the supporting information must be reviewed

DO NOT SUBMIT A NEW CLAIM as notification of payment or refusal will appear on a future Statement of Assessment.

63A SCHEDULE OF BENEFITS

Payment for your claim was reduced or refused in accordance with the Governing Rules and/or the Health Service Code Notes in the Schedule of Medical Benefits. To view the Schedule of Medical Benefits, please go to our website at: www.health.gov.ab.ca.

63AA UNSCHEDULED SERVICES & DESIGNATED HOLIDAYS

Payment was reduced or refused according to General Rules 1.2 and 15 in the Schedule of Medical Benefits or General Rules 1.10 and 17 in the Schedule of Oral and Maxillofacial Surgery Benefits.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 63B to 64B

63B MAXIMUM NUMBER OF CALLS

Payment was reduced as the maximum number of calls for the Health Service Code was reached.

63C INCLUSIVE HEALTH SERVICE CODE

Payment was refused as there is an inclusive Health Service Code in the Schedule of Benefits for these services.

64 SUPPORTING INFORMATION

Payment was refused as text information, an operative or pathology report or an invoice is required to support assessment of the claim.

64AA UNANSWERED CORRESPONDENCE/TELEPHONE RESPONSE

Payment was refused as our requests for additional information were not answered.

64AB RELATIONSHIP

Payment was refused as the relationship of the relative being interviewed was not provided.

64B PROCEDURES REQUIRING APPROPRIATE FACILITY TYPE

Payment was refused as the service claimed is only payable in a hospital or surgical suite.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 64C to 65A

64C INFORMATION PROVIDED

The information provided has been reviewed and payment was:

(a) reduced or refused or
(b) unchanged or
(c) altered and future claims of this nature should be submitted under the applicable health service code. Unlisted procedures are to be claimed only for new procedures not listed in the schedule.

64D ANAESTHETIC AND SURGERY DISCREPANCY

Payment was refused as there is a discrepancy between the Health Service Code shown on the anaesthetic and the surgery claim.

64E DATE CONFLICT

Payment was refused as the date of service does not agree with the anaesthetist's, surgical assistant's or surgeon's claim.

65 HOSPITAL SERVICES/NON-INVASIVE DIAGNOSTIC PROCEDURE/INTERPRETATIONS

Payment was refused as this laboratory/X-ray/non-invasive diagnostic service was provided for a hospital patient. Benefits for this service are the responsibility of the hospital.

65A BLOOD SPECIMEN

This claim was refused as payment cannot be made:

(a) for both obtaining a blood specimen and a lab test requiring blood or
(b) for services performed by non-laboratory facilities

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 65AA to 66

65AA MISCELLANEOUS LABORATORY PROCEDURES

Payment was refused according to the following:

(a) Claims submitted for E1 and/or combination of E2, E3, E4, E5 and E7 for the same date of service are not payable in excess of the listed benefit for E1. Or
(b) The greater benefit is paid when claims are submitted for Health Service Code E1 and E41 or E400 for the same date of service. Or
(c) The greater benefit is paid when claims are submitted for E234 and E235 for the same date of service. Or
(d) A maximum of either one E553 and one E554 or two E553's or two E554's are paid within a 14 day period.

65C DIAGNOSTIC ULTRASOUND

Payment was refused as when claims are submitted for the same date of service for combinations of:

(a) X222 - X233 inclusive
(b) X234 - X244 inclusive
only the greater benefit is paid. Benefits are payable for both the greater of (a) and the greater of (b) when provided on the same date of service. Or
(c) X258 is not payable in addition to X234, X235, X239A, X240, X241, X242, X243.

65D ALLERGY INVESTIGATIONS

Payment was reduced or refused as the maximum benefit payable for the 365 day period was reached.

65E DETENTION TIME

Payment was refused as supporting information must provide a breakdown of the procedures performed during the time of continuous attendance spent with the patient and the time of attendance during the ambulance trip, if applicable.

66 DETENTION TIME

Payment was reduced or refused as:

(a) when a consultation is claimed in association with 03.05A or 13.99J during the same encounter, the consultation is considered to occupy the first 30 minutes of the time spent with the patient.
(b) the greater benefit is paid when health service codes 03.05A or 13.99J are claimed for the same patient encounter.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 66A to 67AB

66A VENTILATORY SUPPORT

Payment was reduced or refused for one of the following reasons:

(a) Ventilatory support may be claimed only once per 24 hour period, regardless of the number of physicians providing care
(b) Ventilatory support is not paid for the same date of service by the same physician who has provided either an anaesthetic or surgical procedure
(c) Ventilatory support is not paid unless provided in approved level 2 and 3 intensive care units
(d) A surcharge is not payable with benefit code 13.62A, but an after hour callback or surcharge is payable under benefit code 03.05P, 03.05R, 03.05Q or 03.05N
(e) In accordance with Governing Rule 5.4.

67 MULTIPLE CHARGES/SAME ENCOUNTER

Payment was refused as claims for multiple services provided in the same encounter require supporting information.

67A PREVIOUS PAYMENT

Payment for this service was refused as:
(a) the claim was previously paid or
(b) the claim was applied at "0" on a previous Statement of Assessment. Requests for a reassessment of applied at "0" claims must be submitted with the original claim number and the appropriate action code of "C" (Change), "D" (Delete) or "R" (Reassess).
(c) the claim was previously paid under a different health service code for the same service in either the Schedule of Podiatry Benefits or the Schedule of Podiatric Surgery Benefits.

Exception: Hospital Reciprocal claims must be resubmitted as described in the Alberta Health and Wellness Hospital Reciprocal Claim Submission Guide.

67AA PAYMENT TO CONTRACT HOLDER/PATIENT

Payment was refused as the benefit for this service was paid to the patient/ contract holder.

67AB PREVIOUS PAYMENT - DIFFERENT HEALTH SERVICE CODE

Payment was refused as a benefit was paid under a different Health Service Code.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 67AC to 69

67AC PREVIOUS PAYMENT

Payment was refused as this benefit was paid to another practitioner.

67AD DUPLICATE - DIFFERENT SERVICE DATE

Payment was refused as this claim appears to be a duplicate of a paid benefit, although the dates of service do not agree. If this is not a duplicate, submit a new claim with supporting information.

67B LOCATION OF SERVICE CONFLICT

Payment was refused as claims were paid for services that the patient received on this date at a different location/hospital. Verify the dates of service and resubmit applicable claims with additional details.

67D MEDICAL STAFF - ASSESSMENT

This claim has been assessed according to the advice received from our medical staff. A review of this assessment by the Assessment Advisory Committee can be requested by submitting a new claim with relevant information.

67DA RELATED ASSESSMENT

Accounts of a similar nature have been reviewed by the Assessment Advisory Committee and this claim has been assessed according to their recommendations.

67DB FINAL ASSESSMENT

This claim has been paid, reduced or refused as recommended by the Assessment Advisory Committee.

68 REDUCED BENEFITS FOR LISTED PROCEDURES

This claim was reduced to the listed benefit as the service listed in:
(a) General Rule 6.8.4 in the Schedule of Medical Benefits or
(b) General Rule 16.3.5 in the Schedule of Oral and Maxillofacial Surgery Benefits,
was not provided in a hospital or approved non-hospital surgical facility.

69 ALTERNATIVE PAYMENT PLAN ADDITIONAL FEE FOR SERVICE PAYMENTS

An additional fee for service payment was paid due to additional supporting documentation for special circumstances.

DENTAL ASSESSMENT

70 PRE/POST-OPERATIVE CARE

This claim was assessed in accordance with General Rule 16.1 in the Schedule of Oral and Maxillofacial Surgery Benefits or General Rule 6.2 in the Schedule of Dental Extended Health Benefits.

70A TWO DENTAL PROCEDURES - TWO INCISIONS

Payment was reduced to 75% of the listed benefit as the major surgical procedure was paid at the full rate.

70AA TWO DENTAL PROCEDURES - ONE INCISION

Services for lesser value procedures are reduced to 75% of the listed benefit, as the major surgical procedure was paid at the full rate.

70D INELIGIBLE DENTAL SERVICES

Payment has been refused as:

(a) tissue conditioning is only payable in conjunction with a denture or reline within five years. There is no reline or denture claimed for this period
(b) tissue conditioning is not payable within three months of a partial or complete denture insertion as this is included with the benefit for the denture
(c) only two tissue conditioning benefits are payable for a denture or reline within five years. You have reached the maximum allowed for a tissue conditioning benefit.

70E TOOTH IDENTIFICATION

Payment has been refused as:

(a) identification of tooth numbers and surfaces are required as applicable
(b) the tooth surface field for this procedure should be blank
(c) the tooth surface(s) indicated is/are NOT valid for the tooth code submitted
(d) the tooth number indicated is not valid for this procedure.

70EA DENTAL EXTRACTION

Payment was refused as our records show this tooth was previously extracted.

70EB TOOTH SURFACE/TOOTH CODE

Payment was refused as the tooth surface or tooth code is invalid.

70F DENTURES/REBASE/RESET

Payment was refused for one of the following reasons:

(a) a benefit was paid for a complete denture within the last 5 years. or
(b) a benefit was paid for a partial denture within the last 5 years.

DENTAL ASSESSMENT (cont'd)

70G RELINE OR REBASE

Payment was refused as benefits were paid for a reline in the past 2 years.

70J INCLUSION WITHIN THE COMPOSITE BENEFIT

Payment was refused as the service is included in the benefit for the major procedure.

70K INELIGIBLE DENTAL MECHANICS SERVICES

Payment was reduced or refused for the following reasons:

a) Only one oral examination per day is payable when a corresponding new denture or reline benefit is provided on or after January 1,2001 and paid by the Alberta Health and Wellness Extended Health Benefits program or
b) only one oral examination is payable for each new denture or reline service provided or
c) an oral examination occurred within 90 days of the denture/reline service. The examination is included in the benefit for the denture/reline or
d) an oral examination is not payable if performed more than 365 days after a denture or reline benefit was provided.

70L DENTAL PROCEDURES

Payment was refused as when multiple services are claimed for the same date of service, the following rules apply:

(a) only the greater benefit of a minor procedure, consultation or any visit is payable when the services and diagnosis are related or
(b) only the greater benefit of a minor (M or M+) procedure or a hospital visit is payable, regardless of the diagnosis or
(c) only the greater benefit of a minor (M+) procedure or a visit is payable when performed in a location other than an Oral and Maxillofacial Surgeon's or Dentist's office, or surgical suite, regardless of the diagnosis or
(d) an office visit benefit is not payable with a minor (M+) procedure and a consultation, regardless of whether the services are performed at different encounters.

WORKERS' COMPENSATION BOARD (WCB)

72 AHC AND WCB CLAIM FOR THE SAME VISIT

Payment was refused as a benefit was paid for a Workers' Compensation Board claim.

72C WORKERS' COMPENSATION BOARD RESPONSIBILITY

Payment was refused as the Workers' Compensation Board will not accept responsibility for this service.

72D WORKERS' COMPENSATION BOARD

The Workers' Compensation Board has accepted responsibility for this claim.

EXTRAORDINARY MEDICAL SERVICES ASSESSMENT FUND (EMSAF)

73 EMSAF REFUSED

Payment was refused as non-residents, Allied Health Providers or subscriber claims do not qualify for EMSAF (Extraordinary Medical Services Assessment Fund) benefits.

73A EMSAF ASSESSMENT

This claim was paid, reduced or refused as recommended by the Extraordinary Medical Services Assessment Fund Committee.

73BA INCORRECT EMSAF CLAIM SUBMISSION

Payment was refused as the claim for Extraordinary Medical Services Assessment Fund was submitted incorrectly. Refer to the Physician's Resource Guide and resubmit appropriately.

73BB NO PAYMENT BY ALBERTA HEALTH CARE

Payment of the Extraordinary Medical Services Assessment Fund portion of the claim was refused as there is no record of an Alberta Health Care payment for this service.

73BC REQUEST FOR EMSAF

Payment was refused as supporting documentation is required for the Extraordinary Medical Services Assessment Fund claim.

73BD NON-INSURED SERVICE

Payment was refused as this service is not insured by Alberta Health Care.

73BE CHANGE OF PAYMENT RESPONSIBILITY

This Extraordinary Medical Services Assessment Fund claim was paid as an Alberta Health Care benefit.

73D BY-ASSESSMENT HEALTH SERVICE CODES FOR EMSAF

Payment was refused as By-Assessment Health Services do not qualify for EMSAF (Extraordinary Medical Services Assessment Fund) benefits.

LIMITS

80 RESIDENCY/GOOD FAITH

Payment was refused as Good Faith Claims must be submitted within 30 days of the date of service.

80B EYE EXAMINATIONS

Payment was refused as this is the second claim for this type of eye exam provided to this patient within the Benefit Period. (July 1 to June 30.)

80BA OPTOMETRIC SERVICES

Payment was refused as either a Complete Vision Examination, a Partial Vision Examination or Single Diagnostic Procedure was paid for the same date of service or the maximum benefit allowed was reached.

80BB OPTOMETRIC SERVICES DEFAULT PRICE ADJUSTMENTS

This is a repayment of benefits that were reduced by implementation of the default price adjustment mechanism in fiscal year 2002/2003.

80C PODIATRIC/CHIROPRACTIC/DENTAL LIMITS

This claim has been reduced or refused as:

(a) the yearly limit for Podiatric benefits has been reached however payment may be reviewed at a later date if we receive changes to other related claims for this patient.
(b) the yearly limit for Chiropractic benefits has been reached.
(c) the calendar year limit for the following dental service(s) has been reached:
    - benefit for only two examinations of any type may be paid in a calendar year
    - benefit for only two films may be paid in a calendar year
    - benefit for panoramic x-rays may be paid once every five calendar years
    - benefit for no more than two units of time (30 minutes) for subgingival scaling/root planing may be paid in a calendar year.

80CA LIMIT ON DAILY VISIT

This claim has been reduced or refused as this patient has reached the limit allowed for this date of service.

80D EYEGLASSES/LENSES/FRAME

Payment has been reduced or refused as this patient has received:

(a) eyeglasses within the last 3 years
(b) lenses/lens within the last 3 years

LIMITS (cont'd)

80E SECOND CHIROPRACTIC X-RAY

Payment was refused as this is the second x-ray for this benefit year. (July 1 to June 30.)

80F 12 MONTH LIMIT

Payment has been reduced or refused as the patient has received this benefit within 12 months.

80G OUTDATED CLAIMS

Payment was refused as the time limit for submission has expired.

80H CONTRACT LIMITS

Payment was reduced or refused as the Contract Limit was reached.

80J PRACTITIONER/BUSINESS ARRANGEMENT LIMITS

Payment was reduced or refused as the limit was reached for the Service Provider or the Business Arrangement.

80K RECIPIENT LIMIT HAS BEEN REACHED FOR APP CONTRACT

Payment was refused or reduced as the recipient has reached capitation rate.

80L ALTERNATIVE PAYMENT PLAN FEE FOR SERVICE

Payment was reduced as the capitation maximum was paid for the month of service.

ADJUSTMENTS

90 PAYMENT REDUCTION

This is an adjustment of a previously assessed item.

90A PREVIOUS CORRESPONDENCE - MUTUAL INFORMATION

This claim has been assessed in accordance with correspondence or telephone call.

90D ADJUSTMENT, RECIPIENT NO LONGER ELIGIBLE FOR COVERAGE

This is an adjustment to update your records only. Payment has not been deducted from your account.

NOTE: The patient is not eligible for Alberta Health Care coverage for the date of service and will be billed by Alberta Health Care.

HOSPITAL RECIPROCAL

95 NEWBORN

Payment was refused as the diagnosis submitted does not agree with the ward rate claimed.

95A INPATIENT/OUTPATIENT SERVICES

Payment was refused as an inpatient and an outpatient service provided at the same hospital on the same day to an individual patient is not payable.

95B DAY OF DISCHARGE

Payment has been reduced as standard ward rate is not payable for the day of discharge.

95C HIGH COST PROCEDURE/ZERO WARD RATE

Payment has been refused as when a high cost procedure and an inpatient standard ward rate are being claimed, two separate claims must be submitted:

a) one claim showing the admission and discharge date and an inpatient standard ward rate, with the claimed amount of zero, and
b) the other claim for the high cost procedure.

95D MULTIPLE TRANSPLANTS SAME HOSPITAL STAY

Payment has been refused as multiple same organ transplants within the same hospital stay are not payable.

95E REDUCED BENEFITS

Payment has been reduced as the number of days between the admit date and discharge date do not agree with the claimed amount.

95F OUTPATIENT SERVICES

Payment has been refused as an outpatient hospital service has been previously paid for this patient for this date of service.

95G MAXIMUM NUMBER OF SERVICES

Payment has been refused as the maximum number of services was paid.

95K CLAIM IN PROCESS

Hold for documentation

95L OUT OF PROVINCE REGISTRATION EXPIRY DATE

Payment has been refused as the out of province registration expiry date on the claim must be blank if the out of province registration number is blank.

HOSPITAL RECIPROCAL (cont'd)

95M UNABLE TO PROCESS UPDATED TRANSACTION

The transaction to update a previously submitted claim cannot be processed as:
(a) the original add transaction cannot be located or
(b) the result of your original claim is unknown, or
(c) the original claim was previously deleted.
Please review your records and resubmit, if applicable.

95T INVALID ICD10CA DIAGNOSTIC CODE

Payment was refused as the diagnostic code on the claim is invalid. Effective April 1, 2002 date of service, only the International Statistical Classification of Diseases and Related Health Problems, 10th Canadian Revision, diagnostic codes (ICD10CA) are acceptable for hospital reciprocal inpatient billing.

HOSPITAL RECIPROCAL

ADJUSTMENTS REQUESTED BY HOME PROVINCE

96A MOTHER/NEWBORN REGISTRATION NUMBER

This is an adjustment of a previously processed claim. Payment was deducted as the mother's out of province registration number may not be used for a baby over the age of three months. Please obtain the baby's correct out of province number and resubmit the claim.

96B DECLARATION FORM INCOMPLETE/INCORRECT

This is an adjustment of a previously processed claim. Payment was deducted as the Declaration Form requested by the patient's home province was:
a) not provided or
b) incomplete or
c) not signed by the patient or parent/guardian

96C OUT OF PROVINCE PATIENT INFORMATION/CLAIM INFORMATION DISCREPANCY

This is an adjustment of a previously processed claim. Payment was deducted because there is a discrepancy between:
a) the home province's patient registration information and the patient information on the claim; or
b) the expiry date on the patient's health card and the expiry date on the claim.

96D OUT OF PROVINCE PATIENT'S COVERAGE NOT EFFECTIVE

This is an adjustment of a previously processed claim. Payment was deducted as the patient's home province has verified that the patient's health card was not valid on the:
a) date of service or
b) admission date or
c) discharge date.

96E INCORRECT CLAIM - ALBERTA RESPONSIBILITY

This is an adjustment of a previously processed claim. Payment was deducted as our records indicate that the patient was an Alberta resident on the date of service.

96F WORKERS' COMPENSATION BOARD RESPONSIBILITY

This is an adjustment of a previously processed claim. Payment was deducted as we have received information advising this service is the responsibility of the Workers' Compensation Board. This claim should be submitted directly to the Workers' Compensation Board.

HOSPITAL RECIPROCAL (cont'd)

96G INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

This is an adjustment of a previously processed claim. Payment was deducted at the request of the patient's home province as an incorrect:
a) service or
b) date of service or
c) rate
was claimed. Please resubmit a new claim using the correct information, if applicable.

96H SECOND OUT-PATIENT VISIT

This is an adjustment of a previously processed claim. Payment was deducted as multiple out-patient visits on the same day for the same patient are not payable.
Note: Charges for additional out-patient visits may not be billed directly to the patient or home province.

HOSPITAL RECIPROCAL

ADJUSTMENTS REQUESTED BY ALBERTA RHA/HOSPITAL

97A INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

This is an adjustment of a previously processed claim. Payment was deducted at the request of the Alberta RHA/hospital as an incorrect:
a) service or
b) date of service or
c) rate
was claimed. Please resubmit a new claim using the correct information, if applicable.

ALTERNATE PAYMENT PLAN

98 CAPITATION PAID

Payment was refused as capitation (payment in lieu of fee for service payments) was paid for this patient for this date of service. Therefore, a fee for service claim is not payable.

98A INVALID HEALTH SERVICE CODE

Payment was refused as this health service code may not be claimed by the business arrangement number indicated on the claim.

98AA FFS/APP Reassessed Claims

Thank you for your payment. Your Fee for Service (FFS) claim transactions have been reassessed and have been applied as Alternate Payment Plan (APP) billing.

ALTERNATE PAYMENT PROGRAM (APP) RELATED

REGISTRATION

98B NON-PATIENT SPECIFIC ULI - OTHER INTERVENTIONS

This transaction was refused as the Non-Patient Specific Unique Lifetime Identifier must be used for services defined as other interventions. For definitions of non-patient and other interventions, refer to the APP information in your Physician's Resource Guide.

PRACTITIONER REGISTRATION

98C LOCUM BUSINESS ARRANGEMENT - FEE FOR SERVICE

This transaction was refused as a practitioner with a locum business arrangement may not be paid fee-for-service under an Alternate Payment Plan practice.

INELIGIBLE SERVICES

98D OTHER INTERVENTIONS - NON-ENROLED PATIENTS

This transaction was refused as services defined as other interventions may not be submitted for non-enroled patients. For a definition of other interventions, refer to the APP information in your Physician's Resource Guide.

98DA OTHER INTERVENTIONS NOT ELIGIBLE UNDER GOOD FAITH

This transaction was refused as services defined as other interventions may not be claimed under the Good Faith program. For a definition of other interventions, refer to the APP information in your Physician's Resource Guide.

ALTERNATE PAYMENT PROGRAM (APP) RELATED (cont'd)

98DB INELIGIBLE OTHER INTERVENTIONS

This transaction was refused as this other intervention service may not be claimed under this Alternate Payment Plan program. For a definition of other interventions, refer to the APP information in your Physician's Resource Guide.

98DC DATE OF SERVICE / ALTERNATE PAYMENT PLAN EFFECTIVE DATE

This transaction was refused as the Alternate Payment Plan program is not active for this date of service.

INCOMPLETE CLAIMS / ADDITIONAL INFORMATION REQUIRED

98E INVALID PAY-TO CODE

This transaction was refused as the pay-to code must be "BAPY" (Business Arrangement Payee) for all Alternate Payment Plan services.

98EA INVALID HEALTH SERVICE CODE - NON-PATIENT SPECIFIC ULI

This transaction was refused as only health service codes that are defined as non-patient may be submitted under the non-patient specific Unique Lifetime Identifier. For a definition of non-patient, refer to the APP information in your Physician's Resource Guide.

98EB INVALID BUSINESS ARRANGEMENT NUMBER

This transaction was refused as the Alternate Payment Plan business arrangement number must be used for all services listed as other interventions. For a definition of other interventions, refer to the APP information in your Physician's Resource Guide.

ALTERNATE PAYMENT PROGRAM (APP) RELATED (cont'd)

ALTERNATE PAYMENT PLAN LIMITS

98F RECIPIENT ANNUAL CAPITATION LIMIT

This service event was reduced or applied at zero as the patient has reached the annual capitation maximum amount payable under this Alternate Payment Plan.