Most Common
Reason Codes on Remittance Advice
Talking Points

Reason Codes on RA - Table of Contents:

Medicare carriers use standardized claim adjustment reason codes called "CARC" and remittance advice remark codes, called "RARC", to explain the claim processing outcomes to the providers and members. These adjustment reason and remark codes are reflected as following:

"Reason Code" with Description listed in

- ECHO Health under "EPP" Remittance Advice
- SCAN's Provider Portal under Claim Tab in Claim Details Screen

"Description Code" listed in ECHO Health under "EOD"

Self-register and gain immediate access to SCAN's provider portal by clicking **SCAN's Provider Portal** or **www.scanhealthplan.com/providers**. Follow instructions and click on **Create Account** for **either** "For SCAN Contracted Providers" or "Non- Contracted Providers". Refer to specific User Guide for guidance or additional information.

1. B11 & N418

Reason Code include:	Guidance on Next Steps for Provider to Take
• B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. • N418 = Misrouted claim. See the payers claim submission instructions. *SCAN supplemental provider claims are responsible for claim payments. Claims should be submitted directly to the supplemental vendor for processing.	1) Refer to **SCAN's Provider Portal** under **Eligibility Tab** in the "*Address to Submit Claims*" field to confirm responsible entity for processing of claim. • Contact Delegate reflected in the "*Address to Submit Claims*" field for status of claim. 2) If provider contacts the Delegate, and they state that SCAN is responsible, then provider should A) validate if service is supplemental, supplemental services should be billed directly to the supplemental payer. B) if medical service complete and submit **Provider Dispute Form (PDR).** 3) Click on **SCAN's Provider Portal** to access and refer to **Resources and Guidelines Tab** and under the Provider Eligibility and Claims Transactions section. • Refer to the ***Provider Disputes & Appeal section*** to select appropriate PDR Form and follow instructions for submission. 4) Provider can also refer to **Provider Section in the SCAN Health Plan Website** under Provider Disputes & Appeals tile. • '**How to Submit Disputes & Appeals**' select appropriate PDR Form and follow instructions for submission.

2. 29

Reason Code include:	Guidance on Next Steps for Provider to Take
• 29 = The time limit for filing has expired.	1) If Provider disagrees with Time Limit Reason Code, provider should submit a **Provider Dispute Form (PDR)** along with proof/evidence of timely filing. Note: internal system notes are not acceptable proof of submission. 2) Click on the **SCAN's Provider Portal** to access and Refer to **Resources and Guidelines Tab** under the Provider Eligibility and Claims Transactions section. • Refer to the Provider ***Dispute & Appeals section*** to select appropriate PDR Form and follow instructions for submission. 3) Provider can also refer to **Provider Section in the SCAN Health Plan Website** under Provider Disputes & Appeals tile

	• '**How to Submit Disputes & Appeals**' select appropriate PDR Form and follow instructions for submission. 4) The PDR should **include proof of timely filing for late filing**. **Example of Good Cause:** Certified mail tracking slip or EDI acceptance report

3. M127, N517 & 252

Reason Code include:	Guidance on Next Steps for Provider to Take
• M127 = Missing patient medical record for this service. • N517 = Resubmit a new claim with the requested information. • 252 = An attachment/other documentation is required to adjudicate this claim/service.	1) In addition to information reflected on Remittance Advice (RA) and our **Provider Portal Claim Details**, providers are also sent a written notice that specifically states what information is missing or required. Therefore, please submit the information (e.g., medical records, corrected claim, or other documentation) that is reflected in letter or RA or our Provider Portal to below address: **SCAN Health Plan Claims Department** **P.O. Box 21543** **Eagan, MN 55121** 2) If a claim has been processed under the **CLAIMS tab** in SCAN's Provider Portal; however, provider is unsure of the status, they should review the below items to help determine status or next steps: • Remittance Advice • Claim Details under **Claim tab** in the SCAN Provider Portal • Provider letter requiring additional information if applicable • **Provider Claim Talking Points & FAQs section** located under Provider Eligibility and Claims Transactions in SCAN Provider Portal 3) If provider still has questions after reviewing these documents, provider can proceed to submit an inquiry. However, they must first sign into the SCAN's Provider Portal. • Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions. 4) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for?

	• What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 5) Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer.*

4. 18

Reason Code include:	Guidance on Next Steps for Provider to Take
• 18 = Exact duplicate claim/service	1) If provider has reviewed RA or SCAN Provider Portal Claim Details, and disagrees or questions the Duplicate Reason Code, provider should submit a Claim Inquiry Status form via the SCAN's Provider Portal. However, they must first sign into the **SCAN's Provider Portal**. • Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions. 2) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for? • What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 3)Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer.*

5. 4, 11 & N565

Reason Code include:	Guidance on Next Steps for Provider to Take
• 4 = Procedure code is inconsistent with the modifier used or a required modifier is missing • 11 = The diagnosis is inconsistent with the procedure code. • N565 = Alert: This non-payable reporting code requires a modifier.	A corrected claim is required for payment consideration. If a provider disagrees with the determination, follow instructions under #2. 1) If a claim has been processed under the **CLAIMS tab** in **SCAN's Provider Portal**; however, provider is unsure of the status, they should review the below items to help determine status or next steps: • Remittance Advice • Claim Details under **Claim tab** in the **SCAN Provider Portal** • Provider letter requiring additional information if applicable • **Provider Claim Talking Points & FAQs section** located under Provider Eligibility and Claims Transactions in SCAN Provider Portal 2) If provider still has questions after reviewing these documents, provider can proceed to submit an inquiry. However, they must first sign into the **SCAN's Provider Portal**. • Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions. 3) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for? • What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 4) Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer.*

6. 16, MA30, MA130 & MA63

Reason Code include:	Guidance on Next Steps for Provider to Take
• 16 = Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. • MA30 = Missing/incomplete/invalid type of bill. • MA130 = Your claim contains incomplete and/or invalid information, and not appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. • MA63 = Missing/incomplete/invalid principal diagnosis.	A corrected claim is required for payment consideration. If a provider disagrees with the determination, follow instructions under #2. 1) If a claim has been processed under the **CLAIMS tab** in **SCAN's Provider Portal**; however, provider is unsure of the status, they should review the below items to help determine status or next steps: • Remittance Advice • Claim Details under **Claim tab** in the **SCAN Provider Portal** • Provider letter requiring additional information if applicable • **Provider Claim Talking Points & FAQs section** located under Provider Eligibility and Claims Transactions in SCAN Provider Portal 2) If provider still has questions after reviewing these documents, provider can proceed to submit an inquiry. However, they must first sign into the **SCAN's Provider Portal**. a. Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions. 3) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for? • What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 4) Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer.*

7. 16 & N463

Reason Code include:	Guidance on Next Steps for Provider to Take
• 16 = Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. • N463 - Missing support data for claim.	1) Our records indicate that the provider's facility is a contracted participant in Optum's Transplant Network. As such, the provider must first submit the claim to Optum for the contracted rate pricing. a) Claim must include the Optum pricing when submitted for payment. b) Provider should contact **Optum at 1-877-801-3507.**

8. 97, M15 & P14

Reason Code include:	Guidance on Next Steps for Provider to Take
• 97 = The benefit for this service is included in the payment/allowance for another services/procedure that has already been adjudicated. • M15 = Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment not allowed. • P14 = The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment.	Allowable for code/services has been combined with primary procedure. If provider disagrees with the determination, follow instructions under #2. 1) If a claim has been processed under the **CLAIMS tab** in SCAN's Provider Portal; however, provider is unsure of the status, they should review the below items to help determine status or next steps: • Remittance Advice • Claim Details under **Claim tab** in the SCAN Provider Portal • Provider letter requiring additional information if applicable • **Provider Claim Talking Points & FAQs section** located under Provider Eligibility and Claims Transactions in SCAN Provider Portal 2) If provider still has questions after reviewing these documents, provider can proceed to submit an inquiry. However, they must first sign into the SCAN's Provider Portal. b. Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions.

	3) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for? • What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 4) Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer*

9. MA20

Reason Code include:	Guidance on Next Steps for Provider to Take
• MA20 = Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of a urethral catheter for convenience or the control of incontinence	Services for primarily related to the use of a urethral catheter for convenience or control of incontinence are not covered; therefore, a **member appeal** should be submitted, and not a provider appeal. (these are not true statements)

10. 256

Reason Code include:	Guidance on Next Steps for Provider to Take
• 256 = Service not payable per managed care contract	Services for out of area and non-urgent/emergent are not covered; therefore, a **member appeal** should be submitted, and not provider appeal. (these are not true statements)

11. N115

Reason Code include:	Guidance on Next Steps for Provider to Take
• N115 = This decision was based on a Local Coverage Determination (LCD), LCD provides guidance to assist in determining whether a particular item or services is covered.	This decision was based on Medicare determination; therefore, refer to Local Coverage Determinations at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs

Reason Codes: Provider Talking Points

Reason Code include:	Guidance on Next Steps for Provider to Take
• B4 = Late filing Penalty • N638= Reimbursement has been made according to the home health fee schedule • N719= Penalty applied based on plan requirement not being met	Provider filed late NOA and first HHA claim has resulted in penalty reduction or zero payment. If provider disagrees with determination, follow instructions under# 2. 1) If a claim has been processed under the **CLAIMS tab** in **SCAN's Provider Portal**; however, provider is unsure of the status, they should review the below items to help determine status or next steps: • Remittance Advice • Claim Details under **Claim tab** in the **SCAN Provider Portal** • Provider letter requiring additional information if applicable • **Provider Claim Talking Points & FAQs section** located under Provider Eligibility and Claims Transactions in SCAN Provider Portal 2) If provider still has questions after reviewing these documents, provider can proceed to submit an inquiry. However, they must first sign into the **SCAN's Provider Portal**. c. Go to **Resources and Guidelines tab** then the Provider Eligibility and Claims Transactions section. Scroll down and click on ***Processed Claim Inquiry*** *folder* to locate form and follow instructions. 3) Portal form will allow documentation to be uploaded with inquiry. See below examples for why to submit an Inquiry: • What is the denial for? • What additional information is required for processing? • Provider is requesting a member's MOOP Accumulator amount. • Track a Certified Claim/Medical Records 5) Acknowledgement email will be sent back to the provider acknowledging receipt of inquiry and advising that *SCAN will make every attempt to respond in 14 calendar days, however some requests may take longer.*