Attachment 20 - ICE - Claim Denial Reasons Guide – IEHP DualChoice

CONTRACTED

This section should be utilized for

contracted providers only.

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| **Applicable Situation/Type of Service** | **Contracted Provider Denial**  **Denial Language** | **Comments**  **Caution**: These denials need to clearly indicate that there is no member liability and that nay disagreement must be resolved between the parties so that the member is not billed. | **Denial Notice to Member and or Provider** | **Situation Code** |
| Medical Records Requested and not received (services other than those related to emergency room) | Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim in not payable by {Health Plan}. You are a contracted provider with {PMG / IPA Name} and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | For use when contracted provider has not submitted requested medical records. The medical necessity decision cannot be made without the medical records.  (Note: CMS expects plan providers to submit necessary records in a timely manner). | Provider Only | CONT-06 |
| Outpatient Services (office visits, lab, diagnostic imaging) | According to our records, there is no authorization for the services rendered. Contracted providers are required to provide documentation or other evidence that the member was advised prior to the services being rendered that they may be financially responsible for such services. You are a contracted provider with (PGM / IPA Name) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | Contracted providers should not provide unauthorized services unless the member is informed in advance of liability for the services and agrees to pay for non-covered care. Such conversations must be documented prior to the non-covered service services being rendered. Use caution when the member identifies self as Medicare fee-for-service and not HMO, as specialists may be unaware of MA HMO coverage initially. | Provider Only | CONT-01 |
| Contracted Hospital or Provider Services (non-emergent - no triage call) | Emergency services are services needed immediately due to sudden illness, injury, or prudent layperson perception, and additional time spent to reach the member’s assigned Medical Group or IPA would have meant risk of permanent damage to the member's health. The services you provided do not meet this definition and therefore required that you obtain prior authorization or provide documented proof the member was advised prior to services being rendered that they may be financially liable for such services. As a contracted provider, you are precluded from billing the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM. | Emergency services are defined in the regulations to include prudent layperson standards, but there are also requirements for contracted providers.  This denial reason is for use when contracted hospital services are non-emergent.  Example: An ER treats minor problems without triage or phone call to PCP for authorization. (Note: Initial triage of the condition is covered). | Provider Only | CONT-02 |

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| Applicable Situation/Type of Service | **Contracted Provider Denial**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Contracted Facility  (delay in care resulted in unnecessary days) | Medical Management has reviewed the care provided and determined that a delay in services provided resulted in unnecessary inpatient days listed above. As a contracted provider, you are not allowed to balance bill the member for these non-covered services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | For use when delay in care or delay in discharge resulted in additional facility days that are unapproved and must be written off by the provider under the terms of their agreement.  **Cautions**: A claim with only this problem can result in a denial. However, if the claim can be properly denied for any other reason, a denial notice appropriate to that reason should be issued without a request for further information and situation code ERIA-01 would not be used. | Provider Only | CONT-03 |
| Not Medically Necessary | The services provided were not reasonable and or medically necessary for the patient’s condition based on the medical records received and were not authorized. You are a contracted provider with (PMG/IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | For use when IPA has confirmed that there is no authorization on file and medical records requested/received do not meet medical necessity requirements. Requires UM review.  Contracted/Affiliated providers should not provide services that are not medically necessary unless the member is informed in advance of liability for such services and agrees to pay for non-covered care. | Provider Only | CONT-07 |
| Contracted In-Area Emergency Services  (non-emergent) (presenting circumstances fail test) | Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to the member’s health. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | The denial language addresses both the non-urgent/emergent situations in area and the lack of authorization for routine care. CMS applies the prudent layperson rule in evaluation of emergency services.  If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to ER) and services were clearly non-urgent/ emergent, the language listed to the left should be modified to exclude the last sentence.  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Provider Only | ERIA-01 |
| Contracted In-Area Urgent Care Services (non-urgent) (presenting circumstances fail test) | *Urgently needed services* means covered services that are not emergency services, provided when the enrollee is in the service or continuation area but the organization provider network is temporarily unavailable or inaccessible when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM. | The denial language addresses both the non-urgent situations in area and the lack of authorization for routine care  If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to UC) and services were clearly non-urgent/emergent, the language listed to the left should be modified to exclude the last sentence. | Provider Only | UCIA-01 |

NON-CONTRACTED

This section should be utilized for

Non-contracted providers only.

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| Applicable Situation/Type of Service | **Non-Contracted Provider Denial**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Required Claim Data Missing or Spoiled | [This page presents an approach to developing these problem claims when they are received from non-contracting providers. Please note that unlike for contracting provider claims on the preceding page, non-contracting provider claims cannot initially be denied for lack of complete, correct CMS required encounter data elements. CMS required data elements includes submission of a complete claim including complete diagnosis coding required for submission of risk adjustment information to CMS. Such incomplete claims from non-contracted providers are defined as non- clean and should be developed for up to 60 calendar days. If the claim data remains incomplete after requesting complete information, the claim should be denied on day 60 for incomplete information. ] | Under Medicare regulations, a claim with incomplete data, including proper diagnosis coding required by CMS for submission for risk adjustment, is not a clean claim. Accordingly, we have up to 60 calendar days to work with non-contracted providers by asking them to provide complete claims data so that a proper evaluation of the claim can occur. Typically two requests should be made to the provider for complete claims data. If a complete claim is not received prior to day 60, the claim can be denied as an incomplete claim. To develop the claim, the text below is recommended for requesting that a non-contracted provider submit a corrected claim. (Please see contracted section for language to be sent to a contracted provider.)  Medicare requires us to report more complete information than you provided on this claim. Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. Unless otherwise specified, the missing or deficient items include one or more of the items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed.  {INSERT EITHER THE CMS-1500 OR UB-92 LIST FROM THE PRIOR PAGE HERE}  **Important Note:** If you are dealing with a non-contracted provider, you have up to the 60th calendar day to develop the claim, but at that time, you must pay or can only deny when missing any of the CMS required fields. | [Not Applicable] | [Not Applicable] |

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| Applicable Situation/Type of Service | **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Non-Contracted In-Area Emergency Services  (non-emergent) (presenting circumstances fail test) | Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Use of non-Plan providers in nonemergency situations is not payable by {Name of Health Plan} | The denial language addresses both the non-urgent/emergent situations in area and the lack of authorization for routine care. CMS applies the prudent layperson rule in evaluation of emergency services.  CAUTION: Only to be used If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to ER) and services were clearly non-urgent / emergent, the language listed to the left should be modified to exclude the last 2 sentences.  NOTE: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Yes | ERIA-04 |
| Non-Contracted  In-Area Urgent Care Services (non-urgent) (presenting circumstances fail test) | . *Urgently needed services* means covered services that are not emergency services, provided when the enrollee is in the service or continuation area but the organization provider network is temporarily unavailable or inaccessible when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan. | The denial language addresses both the non-urgent situations in area and the lack of authorization for routine care. If there is clear documentation that the member is responsible for the service (i.e., PCP was available and member was instructed to go to PCP office but chose to go to UC) and services were clearly non-urgent/emergent, the language listed to the left should be modified to exclude the last sentence. | Yes | UCIA-02 |
| Medical Records Requested and not received (services other than those related to emergency room) | Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by [Health Plan}. | For use when non-contracted provider has not submitted requested medical records. The medical necessity decision cannot be made without the medical records. Member may be billed. | Yes | NON-01 |
| Not Medically Necessary | The services provided were not reasonable and or medically necessary for the patient’s condition based on the medical records received and were not authorized. | For use when IPA has confirmed that there is no authorization on file and medical records requested/received do not meet medical necessity requirements. Requires UM review.  **Caution:** If a Plan provider arranges, refers, or renders services that are not medically necessary without advising the member of non-coverage and financial liability in advance, the member is not financially liable for the services. | Yes | NMN-01 |

CONTRACTED / NON-CONTRACTED

This section may be utilized for

Contracted and Non-contracted providers.

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| Applicable Situation/Type of Service | **Denial Language** | **Comments**  **Caution**: Do not deny to member without verification of eligibility through the plan. Forward to the appropriate Service Partner or Health Plan with whom the member is eligible | Denial Notice to Member and or Provider | Situation Code |
| Incomplete or Invalid Claim  (Initial Claim Development) | Your claim contains incomplete and/or invalid information and no appeal rights are afforded because we are not able to process the claim. Please submit a new claim with the complete/correct information. The following data element(s) are required {insert specific claim data element required}. | Under Medicare regulations, a claim with incomplete data, including proper diagnosis coding required by CMS for submission for risk adjustment, is not a clean claim. Accordingly, we have up to 60 calendar days to work with providers by asking them to provide complete claims data so that a proper evaluation of the claim can occur. Typically two requests should be made to the provider for complete claims data. If a complete claim is not received prior to day 60, the claim can be denied as an incomplete claim. To develop the claim, this message is recommended for requesting that a provider submit a corrected claim.  Required Claim Data Elements:   |  |  | | --- | --- | | CMS-1500: | UB-04/CMS-1450: | | Billing Provider Name | Billing Provider Name | | Federal Tax Number | Patient Control Number | | Patient's Name | Type of Bill | | Patient’s Address | Federal Tax Number | | Date of Birth | Statement Covers Period | | Sex | Patient's Name | | Service Date | Patient’s Address | | Diagnosis Code | Date of Birth | | Procedure, Service, Supply Code | Sex | | Days or Units | Admission Date | | Place of Service | Priority of Admission | | Anesthesia/Oxygen Min. | Origin for Admission | | NPI | Discharge Status | | Insured’s Name | Value Codes & Amounts | | Patient’s Relationship | Revenue Code | | Insured’s ID | HCPCS/Rates/HIPPS | |  | DOS / UOS | |  | Total Charges–n/a for EDI | |  | Non-Covered Charges | |  | Payer Id | |  | Release of Information | |  | NPI | |  | Insured’s Name & ID | |  | Patient’s Relationship | |  | diagnosis& procedure Code Qualifier | |  | Principle or Admitting Diagnosis Code | | Provider Only | INC-01 |

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| Applicable Situation/Type of Service | **Denial Language** | **Comments**  **Caution**: Do not deny to member without verification of eligibility through the plan. Forward to the appropriate Service Partner or Health Plan with whom the member is eligible | Applicable Situation/ Type of Service | Denial Language |
| Incomplete or Invalid Claim  (Reject/Deny due to non-receipt of corrected claim) | Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. You have not responded to our previous request for the specific required data. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed. | NOTE: This message is to be used at the expiration of the 60-day development period and when a corrected claim has not been received.  If the information is received after the actual denial notice has been sent, the claim is treated as a new claim. | Provider Only | INC-02 |

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| Applicable Situation/Type of Service | **Eligibility**  **Denial Language** | **Comments**  **Caution**: Do not deny to member without verification of eligibility through the plan. Forward to the appropriate Service Partner or Health Plan with whom the member is eligible | Denial Notice to Member and or Provider | Situation Code |
|  |  | Eligibility Note related to liability for services under MA:  For **Coverage that Begins or Ends During an Inpatient Stay (MMA §422.318), Medicare has expanded the definition for services for which we have liability until discharge.** Previously Plan remains liable until discharge for any PPS (e.g. DRG) hospital services for a member who is an inpatient at the time of disenrollment. This list has expanded to include acute rehab hospitals, distinct part rehab units, and long term care hospitals.  Physician services continue to revert to Medicare (or any new MA Plan) as of the date of disenrollment. The reverse applies on enrollment. Medicare (or the prior MA Plan) pays for the hospitalization until discharge, but the current Plan pays for physician charges upon enrollment. |  |  |
| Predates Eligibility with Plan | The date you received medical services on the above claim was prior to your effective date of eligibility with {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered. | Applicable when services rendered prior to HMO enrollment date. | Yes  (note caution) | ELIG-01 |
| In-between Eligibility | The date of service is between your eligibility for {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered. | Applicable when services rendered in between HMO enrollment dates. **Caution**: Denials that read "Not eligible with IPA or medical group at the time of service" are inappropriate denials. Contact Plan to verify eligibility and for routing instructions.  **NOTE**: If the DOS is between eligibility with 2 different Health plans please refer to ELIG-01 or ELIG-02 based on the closest date of eligibility. | Yes  (note caution) | ELIG-04 |
| Postdates Eligibility with Plan | The date you received medical services on the above claim was after your effective date of disenrollment with {Name of Health Plan}. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered. | Applicable when service rendered after HMO disenrollment date.  **Caution**: Denials that read "not eligible with IPA or medical group at the time of service" are inappropriate denials. Contact Plan to verify eligibility and for routing instructions. | Yes  (note caution) | ELIG-02 |
| Service Postdates Member’s Death | Our records show the date of service was after the date of death. | Applicable for services billed with a date of service after the members date of death (e.g. post death transportation to a mortuary, hospital bed charges post death until pick up, pathology read post death). | Provider Only | ELIG-03 |

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| Applicable Situation/Type of Service | **Emergency and Urgently Needed Services**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| In-Area Emergency Services  (records not received) | Medical records requested were never received. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. The services received and circumstances do not meet these requirements based on the information available. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM. | The denial language addresses situation where an emergent situation is not evident based on the information available and adequate development took place, but medical records were not received.  CAUTION: If non-contracted provider is rendering services, the language listed to the left should be modified to exclude the last sentence.  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Yes  (note caution) | ERIA-02 |
| In-Area  (partial denial of inappropriate services) | Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis. | Use after medical review when you are making a partial denial of a selected line item(s) for unrelated or inappropriate services provided after triage and there is evidence that the member had accepted liability.  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Yes | ERIA-03 |
| Out-of-Area Emergency Services (not urgently needed) | Emergency services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. The services received were not emergent and were not authorized. | Emergently needed services are by definition applicable to out-of-area care. Denials for out-of-area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria. CMS applies the prudent layperson rule in evaluation of emergency services.  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Yes | EROA-01 |
| Out-of-Area Urgently Needed Services  (not urgently needed) | . *Urgently needed services* means covered services that are not emergency services, provided when an enrollee is temporarily absent from the MA plan’s service area and when the services are medically necessary and immediately required. As a result of an unforeseen illness, injury or condition and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan. | Urgently needed services are by definition applicable to out-of-area care. Denials for out-of-area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria..  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-urgently problem during treatment for an urgent situation, per CMS Manual Pub 100-16 | Yes | UCOA-01 |
| Out-of-Area Emergency Needed Services (records not received) | Emergent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. Medical records requested were never received. The services received cannot be determined to meet these requirements based on the information available. | Emergently needed services are by definition applicable to out-of-area care. Denials for out-of area care should be based on the urgently needed services criteria, which is more liberal than the in-area emergency criteria.  CMS applies the prudent layperson rule in evaluation of emergency services.  **NOTE**: Medicare Advantage organization is not responsible for the care provided for unrelated non-emergency problem during treatment for an emergency situation, per CMS Manual Pub 100-16 | Yes | EROA-02 |

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| Applicable Situation/Type of Service | **Maximum Allowable Benefit**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Chiropractic (non-Medicare covered) | The maximum calendar year additional chiropractic benefit is {#} visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time. Please refer to your Health Plan's member materials for benefit guidelines. | Plan benefits for routine chiropractic services vary. Please refer to the Plan's member materials for benefit guidelines | Yes | MACH-01 |
| Inpatient Psychiatric | Inpatient psychiatric care is covered according to Medicare guidelines and is limited to 190 days per lifetime in a Medicare certified psychiatric hospital. Our records indicate you reached 190 lifetime days on {date}. | Coverage is limited to 190 lifetime inpatient days if services are provided in a Medicare certified psychiatric hospital. Inpatient psych days in a general hospital psych unit do not count towards the lifetime 190 day limit and would continue to be Medicare-covered even if the 190 day limit has been reached.  **Caution**: If a member exhausts the 190 day lifetime maximum at a Medicare certified psychiatric hospital, they may qualify for inpatient benefits at a general hospital's psychiatric unit. | Yes  (note caution) | MAPY-01 |
| Podiatry  (non-Medicare covered) | The maximum calendar year additional podiatry benefit is {#} visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time. | Plan benefits for routine podiatry services vary. Please refer to the Plan's member materials for benefit guidelines | Yes | MAPO-01 |
| Prescription Drugs  (non-Medicare  covered) | The maximum calendar year benefit allowance for outpatient prescription drugs is ${ benefit max amount }. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time. | Benefit maximums should exclude Medicare covered drugs and biologicals. Please refer to the Plan's member materials for benefit coverage guidelines.  Caution: Per ACA, non-grandfathered plans and select grandfathered plan do not have an annual or lifetime $$ amount benefit maximum under the essential health benefit. | Yes | MARX-01 |
| Skilled Nursing Facility | Skilled Nursing Facilities are covered by {Name of Health Plan} up to 100 days per benefit period. Our records indicate that on {date}, you reached your 100 day benefit maximum for this benefit period. | Coverage is limited to a 100 day Maximum Medicare Benefit for Skilled Nursing per benefit period (Requires Notice of Non-Coverage).  **Caution**: Some Plans may provide additional SNF benefits. Refer to the Plan's member materials for benefit guidelines. | Yes  (note caution) | MASN-01 |
| Miscellaneous  (Insert other specific benefits with annual maximums | {Insert other specific benefits with annual maximums} are covered by {Name of Health Plan}. Our records indicate that on {date}, you reached your {benefit maximum} for {Insert other specific benefits maximums}. | Benefit maximums must be supported by the Plan's member materials.  SPECIFIC denial information is required. | Yes | MAMI-01 |

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| Applicable Situation/Type of Service | **Not a Covered Benefit**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Ambulance  (not medically necessary) | Ambulance transportation is covered if you could not have used another means of transportation without endangering your health. The transport you received does not meet this criterion | For use where transport is not medically necessary and not authorized. | Yes | NCAM-01 |
| Ambulance  (no patient transport) | As you were not transported by ambulance, the services are not covered by Medicare or {Name of Health Plan}. | For denial of services where no patient has been transported, such as paramedic intercept calls where no transport occurs. | Yes | NCAM-02 |
| Assistant Surgeon  (Medicare guidelines) | Medicare does not pay for an assistant surgeon for this procedure/surgery. Payment for the assistant surgeon is denied by {Name of Health Plan}. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE SERVICES. | Denial to provider per Medicare guidelines. Member should not be involved. The member has no financial responsibility for these services. | Provider Only | NCAS-01 |
| Bundling  (Medicare guidelines) | Medicare does not pay separately for this service. Payment is included in another service the member has received. The member has no financial liability and should not be billed for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE SERVICES. | For use in rebundling services per Medicare guidelines. Plans cannot apply to non-contracted Clinical Lab, Radiology (facility component), DME, Ambulance, ESRD Medications, or Home Health. The member has no financial responsibility for these services. | Provider Only | NCBU-01 |
| Chiropractic  (Medicare criteria) | Medicare coverage for chiropractic care requires that you be diagnosed with subluxation of the spine. The services received do not meet this criterion and are not covered by Medicare or {Name of Health Plan}. | For denial of service or claim where Medicare criteria are not met.  **Caution**: Some Plans may provide additional chiropractic care benefits. Refer to the Plan’s member materials for benefit guidelines. | Yes  (note caution) | NCCH-01 |
| Cosmetic | The procedure you received is considered a cosmetic procedure. Cosmetic procedures are not a benefit covered by Medicare or {Name of Health Plan}, except for post-accident repair/reconstruction. Please refer to your Health Plan's member materials for benefit guidelines. | Cosmetic procedures are normally excluded with specific exceptions for post-accident repair/reconstruction or where applicable as a prosthetic, such as post mastectomy. Please refer to the Plan's member materials for benefit guidelines. | Yes | NCCO-01 |

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| Applicable Situation/Type of Service | **Not a Covered Benefit**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Dental Services | Dental services are not a benefit covered under Medicare or {Name of Health Plan} except for surgery related to the jaw or any structure related to the jaw or any facial bone. Please refer to your Health Plan's member materials for benefit guidelines. | Caution: Members may have additional coverage through their HMO for non-Medicare covered dental services. Please refer to the Plan member materials for benefit guidelines. | Yes  (note caution) | NCDS-01 |
| DME-Durable Medical Equipment (does not meet Medicare DME criteria) | Medicare defines durable medical equipment as an item that is medical in nature, can withstand repeated use, and is used in the home. The item received does not meet these requirements and is not payable by Medicare or {Name of Health Plan}. | For use when the item does not meet Medicare DME criteria.  **Caution**: If a plan physician (PCP or SCP) prescribes equipment that is not covered, the member cannot be held liable without prior disclosure of financial liability. | Yes  (note caution) | NCDM-01 |
| DME-Durable Medical Equipment (not authorized) | The durable medical equipment received was not prescribed/authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by {Name of Health Plan}. | For use when DME is not prescribed/authorized by a Plan physician.  **Caution**: IPA needs to coordinate with Plan before issuing denials for DME to avoid possible duplication. | Yes  (note caution) | NCDM-02 |
| Hearing Aids | Hearing Aids are not a benefit covered under Medicare or {Name of Health Plan}. | **Medicare does not cover Hearing Aids.**  **Caution**: IPA needs to coordinate with Plan for possible additional coverage. | Yes (note caution) | NCHA-01 |
| Home Health (does not meet skilled guidelines) | Home health services must include intermittent skilled care (skilled nursing, PT, or speech therapy) to qualify under Medicare guidelines. The services received were not skilled care and are not payable by Medicare or {Name of Health Plan}. | For use when the member requests home health care and does not require skilled care. | Yes | NCHH-01 |
| Home Health (member not homebound) | Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services received are not payable by Medicare or {Name of Health Plan}. | For use when the member requests home health care and does not meet Medicare criteria for being homebound or for coverage determinations for Out of Plan services under emergent or urgently needed criteria. | Yes | NCHH-02 |

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| Applicable Situation/Type of Service | **Not a Covered Benefit**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Home Health (not authorized) | The home health services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by {Name of Health Plan}. | For use when patient self refers or has home health ordered by an Out of Plan physicians.  **Caution**: IPA needs to coordinate with Plan before issuing denials for Home Health Care | Yes  (note caution) | NCHH-03 |
| Non-Formulary Drugs | The {list specific prescription drug/ medication} you received is not on the listing or formulary of approved drugs for {Name of Health Plan}. Non-formulary drugs are not a covered benefit. Please refer to your Health Plan's member materials for benefit guidelines. | Prescription drugs/medications are typically Plan liability. This denial is applicable where a closed formulary is stipulated in the member materials and a claim is received for non-formulary drugs. | Yes  (by plan) | NCRX-01 |
| Non Medicare/FDA Approved Drugs or Devices | { **list specific drug or devise** } is not approved by Medicare/the FDA and is excluded from coverage by {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines. | For denials of services or equipment not approved by Medicare/the FDA for use under the Medicare Program or otherwise specifically excluded in the member materials. Please refer to the Plan's member materials for benefit guidelines. | Yes | NCRX-02 |
| Not Authorized In-Area Non-ER Services  (If ER / emergent, use emergency denial message) | When you enrolled in a Medicare Advantage Plan, you selected a Primary Care Physician to coordinate/authorize your medical care. The services received were not authorized and are not payable by {Name of Health Plan}. | **Caution**: If a Plan provider arranges, refers, or renders services that are not medically necessary without advising the member of non-coverage and financial liability in advance, the member is not financially liable for the services. | Yes  (note caution) | NCNA-01 |
| Over the Counter Items/Medications | The drugs/medication received is available over the counter without a prescription and are not a benefit covered by {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines. | Over the counter drugs/medicines, supplies and items are typically excluded under the EOC / Member Agreement. Please refer to the Plan's member materials for the benefit guidelines. OTC items would include but are not limited to: mouthwash, supplements, homeopathic, antacids, thermometers, insoles, hearing aid batteries, etc. (refer to MCM Chapter 4, section 40.3) | Yes  (by plan) | NCRX-03 |
| Personal Comfort Items | The {list specific item} you were provided is considered a personal comfort item and is not a covered benefit under Medicare or {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines. | (For use with facility claims only) Personal comfort items are not a covered Medicare benefit. This would include charges for telephone, slippers, videos, bathrobes, etc…  **Caution**: For non-facility related supplies and items billed, refer to NCRX-03. Refer to MCM Chapter 4, section 40.3 for examples of non-covered items. | Yes | NCPC-01 |

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| Applicable Situation/Type of Service | **Not a Covered Benefit**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Podiatry | Podiatry services for routine foot care, such as toe nail trimming, or corn/callus removal is not a benefit covered under Medicare or {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines | **Caution**: Medicare covers routine foot care for specific conditions related to diabetic & systemic foot disease. Members may have additional podiatry benefits with direct access for routine podiatry services. Please refer to the Plan's member materials for benefit guidelines. | Yes  (note caution) | NCPO091 |
| Shoe Orthotics | Shoe orthotics, including inserts and modifications, are only covered by Medicare or {Name of Health Plan} for diabetics or when the shoe is an integral part of a leg brace. Please refer to your Health Plan's member materials for benefit guidelines. | **Caution**: Some Plans may offer additional shoe orthotic coverage. Please refer to the Plan's member materials for benefit guidelines. | Yes  (note caution) | NCSO-01 |
| Skilled Nursing Facility (custodial care or not daily SNF care) | Medicare guidelines require that skilled nursing facility care be needed daily, as certified by your physician. The services received were custodial in nature and/or not required daily. They are not covered by Medicare or {Name of Health Plan}. | For use when care is custodial or daily skilled care is not medically necessary. | Yes | NCSN-01 |
| Skilled Nursing Facility  (not authorized) | The skilled nursing facility services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not a covered benefit under {Name of Health Plan}. | For use when care is not authorized, i.e. member self refers or is referred by a non-Plan physician.  **Caution**: IPA needs to coordinate with Plan before issuing denials for Skilled Nursing Care. | Yes  (note caution) | NCSN-02 |
| Miscellaneous | {List specific item(s)} is not a Medicare covered benefit and excluded from coverage under {Name of Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines. | For use with other specific services that are not a covered benefit. | Yes | NCMI-01 |

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| Applicable Situation/Type of Service | **Advanced Diagnostic Imaging Accreditation** | **Comments** | Denial Notice to Member and Provider | Situation  Code |
| ADI – Rendered by non-accredited provider | Medicare does not pay for services rendered by a non-accredited provider. Payment for this advanced diagnostic imaging service is denied .THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS SERVICE. | For use when an advanced diagnostic imaging service listed on the CMS listing of CPT codes requiring accreditation and the rendering provider is not found on the accreditation lists of the accreditation organizations recognized by CMS. | Provider Only | NCAD-01 |

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| Applicable Situation/Type of Service | **Provider Opted Out of Medicare** | **Comments** | Denial Notice to Member and Provider | Situation  Code |
| Claim is submitted **inadvertently** by the opt-out physician/practitioner or beneficiary | The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount. | For use when the rendering provider has opted out of Medicare.  **Caution**: See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. | Yes | NCOO-01 |
| Claim is submitted **knowingly and willfully** by the opt-out physician/practitioner | The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount. | For use when the rendering provider has opted out of Medicare.  **Caution**: See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers | Yes | NCOO-02 |

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| Applicable Situation/Type of Service | **Workers Compensation**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Any visit documented as workers compensation | According to our records the services that have been rendered fall under your worker’s compensation case. | For use when member has filed a worker’s compensation case. Evidence of first report of injury should be indicated. | Yes | WC-01 |

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| Applicable Situation/Type of Service | **Coordination of Benefits**  **Denial Language** | **Comments** | Denial Notice to Member and or Provider | Situation Code |
| Requested information not received from member | Our records indicate that you may have other insurance coverage. Coordination of benefits information (primary insurance carrier information) was requested from you and has not been received. In order to determine financial liability this information is required. As this information has not been received, this claim in not payable by [Health Plan}. | CAUTION: Before denying, you must be able to demonstrate two requests for information have been sent to the member.  For use when records indicate other insurance coverage and information has not been received from member. | Yes | COB-01 |

[THIS PAGE AND THE PAGES THAT FOLLOW ARE INFORMATIONAL AND ARE NOT PART OF THE GUIDE, ITSELF.]

The following documents are provided for your reference and information to aid you in working with this ICE Tool:

* History of Revisions
* Instructions
* FAQs

**History of Revisions**

01/2016 - Added denial reason codes CONT-07 and NMN-01 for services determined to be not medically necessary.

01/22/14 Corrected grammatical errors. Removed denial reasons CONT-04 and CONT-05. New denial reasons added for Urgent Care UCIA-01 UCIA-02. Added language pertaining to ACA non-grandfathered plans. Removed diagnosis codes related to chiropractic care denial reason NCCH-01. Added examples of OTC items NCRX-03 changed description to include items. Added a caution to personal comfort items NCPC-01. Added new denial reason for ADI regulations mandated by CMS NCAD-01. Added new denial reasons for opt out providers NCOO-01 NCOO-02.

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| 11/2005 | Updated ERIA-01 to be listed only once and added ERIA-04. |
| 05/2005 | Separated document by non-contracted, contracted and non-contracted/contracted. Added headers for, workers compensation, and coordination of benefits. Added new denial reasons for “in-between eligibility”, “medical records not received”, “workers compensation”, “coordination of benefits”, modified Medicare + Choice to Medicare Advantage, modified HCFA-1500 to CMS-1500, added specific diagnosis codes to NCCH-01, added note to ERIA-01, ERIA-02, ERIA-03, EROA-01, EROA-02. Revised verbiage on ERIA-01 and ERIA-02 denial reason. |
| 2/27/03 | No denial reasons have been changed, added or deleted. Several format changes to other elements of this tool were made. Inclusive braces { } were added to distinguish {text inserts} from [instructions or descriptions] in the guide. More about the use of braces is explained on one of the pages below. This revision has included adding this and other informational pages that are not part of the guide itself. They are aids to understanding the guide, including: a history of revisions (this page), instructions, and a place-holder for frequently asked questions (FAQs). |
| 3/01 | The Industry Collaboration Effort (ICE) implemented modifications to comply with the Balanced Budget Act (BBA) and the related Final Rule. Prudent Layperson language was added to denial reasons CONT-3, ERIA-01 and ERIA-02. CONT-04 and CONT-05 were added for use when contracted providers don’t submit claims that include minimally complete encounter data items. Chiropractic denial reason NCCH-01 was revised. HCFA/CMS Region IX reviewed and approved the modifications. |
| 1/24/97 | The original version was presented by the HCFA Managed Care Operations Team (HMCOT) in response to a request from Bruce Fried of HCFA Central Office. It was developed by participating health plans and HCFA Region IX, with input from IPAAC and other participating provider organizations. |

**Instructions**

**Using the Guide**

* All information in inclusive braces { } and the braces themselves must be replaced by inserted text as indicated.
* Please read all comments and cautions very carefully. Consult with a health plan or the ICE Claims Standardization Team if you need assistance or clarification.
* The situation code column shows generic codes to aid in referring to different reasons in this guide. You can change these codes to fit the nomenclature of your own claim system; however, it is a best practice to create a cross-reference list of generic and actual codes so that you can easily refer back to this guide when needed.

**Guidelines for Health Plan Auditors**

* This guide has been reviewed and approved by CMS Region IX. Check with your health plan management before accepting any deviation from the exact text of the denial reasons. Denial reason modifications that omit essential information or make the reason text inappropriate for claim (post-service) denial notices should not be accepted.

**Frequently Asked Questions (FAQs)**

None. May be developed at a future time.