IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202004 JANUARY 28, 2020

IHCP will add adjustment reason codes as valid for proof of primary insurer denied or zero-paid claims

The Indiana Health Coverage Programs (IHCP) has reviewed the current adjustment reason code (ARC) list that the IHCP deems to be valid denial ARCs and is expanding the list. Providers include ARCs when submitting certain claims to the IHCP as proof if the primary insurer does not make a payment, either because the primary insurer denied the claim, or paid zero (for example, the full amount was applied to a deductible or copayment).

Effective February 28, 2020, the IHCP will include the ARCs in Table 1 as valid ARCs for proof that the claim was submitted to the primary insurer, and that the primary insurer either denied the claim, or made zero payment. These codes are in addition to those currently published in the provider reference module, *Claim Submission and Processing* (Table 9) at in.gov/medicaid/providers. The additional ARCs will be reflected in the next regular update to that module.

For the requirements to submit proof of denied or zero-paid claims, see the *Claim Submission and Processing* module. The module explains the options, using the ARC *or* a copy of the explanation of benefits (EOB) from the primary insurer.

Table 1 – Codes added to the list of valid adjustment reason codes for claims denied or zero paid, effective February 28, 2020

ARC	Description
1	Deductible amount
19	This is a work-related injury/illness and thus the liability of the worker's compensation carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the National Council for Prescription Drug Programs [NCPDP] Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
177	Patient has not met the required eligibility requirements.
198	Precertification/notification/authorization/pre-treatment exceeded.
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (**Use only with Group Code PR**) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

continued

Table 1 – Codes added to the list of valid adjustment reason codes for claims denied or zero paid, effective February 28, 2020 (continued)

ARC	Description
203	Discontinued or reduced service.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
245	Provider performance program withhold.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
273	Coverage/program guidelines were exceeded.
274	Fee/Service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
276	Services denied by the prior payer(s) are not covered by this payer.
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.

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