CMS 1500 Claims Submission

HealthPlus provides claims processing through electronic transmission or paper submittals. The CPT and HCPCS codes, including modifiers, should be used to designate professional procedures. ICD-9-CM codes should be used for diagnoses. Specialty providers (vision providers, ambulance services, home health, or skilled nursing agencies) need to refer to the specific coding instructions in your contract, if you have any special provisions therein.

Paper claims should be submitted to:

HealthPlus of Michigan
PO Box 1700
Flint, Michigan 48501-1700

HealthPlus utilizes electronic claims scanning technology to process paper claims. Submission must be on the original CMS 1500 (08-05) claim form. It is essential that the requirements listed below are followed to ensure prompt processing of your claims:

- The CMS 1500 (08-05) form must be used and filled out completely in the non-red shaded areas only.
- All claims must be typewritten or computer-generated in a dark print—no hand written claims.
- All data must be contained within each locator box, left justified.
- The patient's 11-digit contract number must be used (9-digit contract number plus suffix.)
- No more than six service lines per claim. Do not try to fit two service lines into one space.
- The procedure code is sufficient—do not type the description.
- Your National Provider Identification (NPI) number, not your tax identification number, must be used in form locator box 33a.
- For paper submission, your HealthPlus legacy number must be in 33b.
- Be sure to enter other health benefit plan information (COB) in form locator box 9.

If you have additional information to include that does not specifically have its own form locator box, please use form locator 19. Without the NPI number, claims payment may be delayed or denied and/or your claim may be returned to you for resubmission. Incomplete or erroneous claims will be returned to the provider for completion and/or correction.

CMS 1500 Form Locator Requirements:

1.a. Insured's ID number (including the appropriate 2 digit suffix)
Example: 12345678-01
2. Patient Name
3. Patient's Birthdate and Sex
19. Reserved for Local Use (if writing text for description/explanation, use this form locator)
21 Diagnosis (ICD9CM code)
24.A. Date(s) of Service

24.B. Place of Service
24.C. Emergency indicator (EMG) "Y" = yes "Blank" = no
24.D. Procedure(s), Services or Supplies and Modifiers
24.E. Diagnosis Pointer – relate items 1,2,3 or 4 in Field 21
24.F. Charges
24.G. Days or Units
24. J. NPI of Rendering Provider
25. Federal Tax ID Number
26. Patient's account number (optional)
27. Must check appropriate box if Medicare is the primary payer and HealthPlus is a secondary payer
28. Total Charge
29. Amount Paid
30. Balance Due
31. Signature of Physician or Supplier. Indicate the individual provider's name or supplier who performed services. If a physician assistant or nurse practitioner is the provider of service, you must use the NPI provider number of the physician who oversees the assistant or practitioner in form locator box 33a.
32. Service Facility Location Information
32. a 10 digit NPI only
32. b. Provider Legacy Number
33 Provider Billing Address, ZIP code and telephone number must be placed in box 33.
33a. 10 digit NPI only
33b. Provider legacy number

When HealthPlus is the secondary payer, the following form locator fields are required:

9. Other insured's name
9.A. Other insured's policy or group numbers

Is patient's condition related to:

10.A. Employment? (current or previous)
10.B. Auto Accident? Place: (State)
10.C. Other Accident?
11. Insured's Policy Group or FECA Number
11.A. Insured's Date of Birth
11.B. Employer's Name or School Name
11.C. Insurance Plan Name or Program Name
11.D. Is There Another Health Benefit Plan? If yes, return to and complete items 9 a-d

UB-04 Claims Submission

The UB-04 claim form is accepted for institutional claims. The UB-04 manual provides a complete description of the definition, purpose, billing requirements and instructions for each form locator on the claim form. Refer to this manual for general billing instructions.

Hospital claims should be submitted to:

HealthPlus of Michigan
PO Box 1700
Flint, MI 48501-1700

Specific requirements for each UB-04 Form Locator element billed to HealthPlus are described on the following pages for your convenience.

HealthPlus UB04 Form Locator Requirements

Claims

Blank = Not Required, R = Required
R* = Required for Specific Circumstances
(refer to Uniform Billing 04 manual)

F.L.	DATA ELEMENT	HEALTHPLUS
1	Provider Name, Address, Telephone Number	R
2	Pay to Name, Address	R*
3a 3b	Patient Control Number Medical Record Number	
4	Type of Bill	R
5	Federal Tax Number	R
6	Statement Covers Period – from/through	R
7	Unlabeled	
8a 8b	Patient Name (Last, First, Middle Initial) Patient ID	R R
9a 9b 9c 9d	Street City State Zip Code	R*
10	Patient Date of Birth	R
11	Patient Sex	
12	Admission Date	R
13	Admission Hour	R
14	Type of Admission/Visit	R
15	Source of Admission	R
16	Discharge Hour	
17	Patient Discharge Status	R
18-28	Condition Codes	
29	Accident State	
30	Unlabeled	
31-34	Occurrence Code/Date	R*
35-36	Occurrence Span Code – from/through	R*
37	Unlabeled	
38	Responsible Party Name/Address	R*
39-41 a-d	Value Codes and Amounts	R*
42	Revenue Codes	R
43	Revenue Code Description	R*
44	HCPCS/Rate/HIPPS Code/Add modifier if applicable	R
45	Service Date	R
46	Units of Service	R
47	Total Charges By Revenue Code	R

Blank = Not Required, R = Required
R* = Required for Specific Circumstances
(refer to Uniform Billing 04 manual)

F.L.	DATA ELEMENT	HEALTHPLUS
48	Non-covered Charges	R*
49	Unlabeled	
50	Payer Name – Primary/Secondary/Tertiary	R
51	Health Plan Legacy ID	R
52	Release of Information – Primary/Secondary/Tertiary	R*
53	Assignment of Benefits – Primary/Secondary/Tertiary	R*
54	Prior Payments – Primary/Secondary/Tertiary	R*
55	Estimated Amount Due – Primary/Secondary/Tertiary	R*
56	Billing NPI	R
57 57b 57c	Other Provider ID – Primary/Secondary/Tertiary Other: Taxonomy Number Prov ID	R* R*
58	Insured's Name – Primary/Secondary/Tertiary	R*
59	Patient's Relationship – Primary/Secondary/Tertiary	
60	Insurer's Unique ID – Primary/Secondary/Tertiary	R*
61	Insurance Group Name – Primary/Secondary/Tertiary	R*
62	Insurance Group Number – Primary/Secondary/Tertiary	R*
63	Treatment Code – Primary/Secondary/Tertiary	R*
64	Document Control Number	
65	Employer Name – Primary/Secondary/Tertiary	
66	Dx Version Qualifier	
67 67a	Principal Diagnosis Code q Other Diagnosis	R R
68	Unlabeled	
69	Admitting Diagnosis Code	R
70	Patient's Reason for Visit Code	R
71	PPS Code/DRG	R*
72	External Cause of Injury Code	R*
73	Unlabeled	R*
74 74a-e	Principle Procedure Code/Date Other Procedure Code/Date	R* R*
75	Unlabeled	
76	Attending – NPI/Qual/ID Attending – Last/First	R*
77	Operating – NPI/Qual/ID Operating – Last/First	R*
78	Other ID – Qual/NPI/Qual/ID Other ID – Last/First	R*
79	Other ID – Qual/NPI/Qual/ID Other ID – Last/First	R*
80	Remarks	R*
81	Code – Code Qual/Code/Value	

Electronic claim submission

The HealthPlus Electronic Data Interchange (EDI) system provides a flexible and simple method of submitting claims in a secure and confidential environment. The CMS 1500 and UB-04 formats are accepted at HealthPlus. HealthPlus strongly encourages all providers to submit claims electronically.

Advantage of electronic billing include:

- Improved processing time
- Faster claims payment
- Reduced paper, environmentally-friendly
- Claims account control

Minimum requirements for electronic data interchange to HealthPlus:

- Hardware and software requirements
  - 56K baud minimum
  - Third party communication software
- Communication Protocol
  - ASCII
  - Kermit
  - Xmodem
  - Ymodem
  - Zmodem
- Communication Settings
  - Bit 8
  - Parity N (o)
  - Stop Bit I
  - Terminal Emulation ANSI or VT-100
  - Baud Rate 56K
- File Formats
  - ANSI X-12 format (HIPAA)
  - Also available 997s (acknowledgement report)
    - 835s (remittance advice)
    - 837s (file extensions)
    - .37P (CMS 1500)
    - .37I (UB04)

For additional information, contact a HealthPlus EDI specialist at:

(810) 230-2084

To set up your software, contact your software vendor.

Process for Submitting Electronic Claims

- For initial set up, call (810) 230-2084
- 835 agreements available upon request.
- A submitter ID number will be assigned in order to download the claims file.
- After completion of the testing process and the provider is at production status, the provider can transfer a file of claims.
- On the next working day when the file is completed, HealthPlus reports back to the provider's mailbox the 997 reports. In the provider's mailbox will be a 997 Functional

Acknowledgement for each file submitted along with a P277 Proprietary Claim Status and U277 Unsolicited Claim Status file. The 977 and U277 files will require software from your vendor in order to process into a readable format. The P277 file can be viewed as a readable format if opened using WordPad, MS Word or any other word processing software package.

- For any non-HIPAA compliant electronic biller, please contact the EDI Department to obtain a companion document or advise HealthPlus of the status of your conversion.
- HealthPlus accepts COB 837 claim files. For more information, contact your vendor, clearinghouse, or HealthPlus EDI department.

COB Data Fields — Claims

Field Description	837 Field Description	837 Mapping Information
Primary Payer Name	Payer Name or Other Payer Name	NM103 Field from 2010BB Loop or 2330B Loop
Primary Payer ID	Payer Identifier or Other Payer Identifier	NM108 Field from 2010BB Loop or 2330B Loop
Claim Level Amount Paid	Other Payer Prior Payment - Actual Other Payer Amount Paid	INST – AMT*C4 Amount or AMT*N1 Amount 2320 Loop PROF – AMT*D Amount 2320 Loop
Claim Level Approved Amount	Other Payer Total Submitted Charges Other Payer Approved Amount	INST – AMT*T3 Amount 2320 Loop PROF – AMT*AAE Amount 2320 Loop
Claim Level Allowed Amount	Other Payer Allowed - Actual Other Payer Allowed - Actual	INST – AMT*B6 Amount 2320 Loop PROF – AMT*B6 Amount 2320 Loop
Claim Level Patient Responsibility Amount	Other Payer Patient Responsibility - Actual	INST – Not Applicable PROF – AMT*F2 Amount 2320 Loop
Claim Level Contractual Adjustment Amount	Claim Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2320 Loop
Claim Level Co-pay Amount	Claim Adjustment Amount	CAS* *3 Amounts 2320 Loop
Claim Level Deductible Amount	Claim Adjustment Amount	CAS* *1 Amounts 2320 Loop
Claim Level Coinsurance Amount	Claim Adjustment Amount	CAS* *2 Amounts 2320 Loop
Service Level Amount Paid	Service Line Amount Paid	SVD02 Amount Field 2430 Loop
Service Level Allowed Amount	Service Line Approved Amount	INST – Not Applicable PROF – AMT*AAE Amount 2400 Loop
Service Level Patient Responsibility Amount	Service Line Adjustment Amount	CAS*PR* Amounts 2430 Loop
Service Level Contractual Adjustment Amount	Service Line Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2430 Loop
Service Level Co-pay Amount	Service Line Adjustment Amount	CAS* *3 Amounts 2430 Loop
Service Level Deductible Amount	Service Line Adjustment Amount	CAS* *1 Amounts 2430 Loop
Service Level Coinsurance Amount	Service Line Adjustment Amount	CAS* *2 Amount s 2430 Loop
Secondary Payer Name	Secondary Payer Name	NM103 Field from 2010BB Loop or 2330B Loop
Secondary Payer ID	Secondary Payer ID	NM108 Field from 2010BB Loop or 2330B Loop
Claim Level Amount Paid	Other Payer Prior Payment - Actual Other Payer Amount Paid	INST – AMT*C4 Amount or AMT*N1 Amount 2320 Loop PROF – AMT*D Amount 2320 Loop
Claim Level Approved Amount	Other Payer Total Submitted Charges Other Payer Approved Amount	INST – AMT*T3 Amount 2320 Loop PROF – AMT*AAE Amount 2320 Loop
Claim Level Allowed Amount	Other Payer Allowed - Actual Other Payer Allowed - Actual	INST – AMT*B6 Amount 2320 Loop PROF – AMT*B6 Amount 2320 Loop
Claim Level Patient Responsibility Amount	Other Payer Patient Responsibility - Actual	INST – Not Applicable PROF – AMT*F2 Amount 2320 Loop

Claim Level Contractual Adjustment Amount	Claim Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2320 Loop
Claim Level Co-pay Amount	Claim Adjustment Amount	CAS* *3 Amounts 2320 Loop
Claim Level Deductible Amount	Claim Adjustment Amount	CAS* *1 Amounts 2320 Loop
Claim Level Coinsurance Amount	Claim Adjustment Amount	CAS* *2 Amounts 2320 Loop
Service Level Amount Paid	Service Line Amount Paid	SVD02 Amount Field 2430 Loop
Service Level Allowed Amount	Service Line Approved Amount	INST – Not Applicable PROF – AMT*AAE Amount 2400 Loop
Service Level Patient Responsibility Amount	Service Line Adjustment Amount	CAS*PR* Amounts 2430 Loop
Service Level Contractual Adjustment Amount	Service Line Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2430 Loop
Service Level Co-pay Amount	Service Line Adjustment Amount	CAS* *3 Amounts 2430 Loop
Service Level Deductible Amount	Service Line Adjustment Amount	CAS* *1 Amounts 2430 Loop
Service Level Coinsurance Amount	Service Line Adjustment Amount	CAS* *2 Amount s 2430 Loop

First Tertiary Payer Name	First Tertiary Payer Name	NM103 Field from 2010BB Loop or 2330B Loop
First Tertiary Payer ID	First Tertiary Payer ID	NM108 Field from 2010BB Loop or 2330B Loop
Claim Level Amount Paid	Other Payer Prior Payment - Actual Other Payer Amount Paid	INST – AMT*C4 Amount or AMT*N1 Amount 2320 Loop PROF – AMT*D Amount 2320 Loop
Claim Level Approved Amount	Other Payer Total Submitted Charges Other Payer Approved Amount	INST – AMT*T3 Amount 2320 Loop PROF – AMT*AAE Amount 2320 Loop
Claim Level Allowed Amount	Other Payer Allowed - Actual Other Payer Allowed - Actual	INST – AMT*B6 Amount 2320 Loop PROF – AMT*B6 Amount 2320 Loop
Claim Level Patient Responsibility Amount	Other Payer Patient Responsibility - Actual	INST – Not Applicable PROF – AMT*F2 Amount 2320 Loop
Claim Level Contractual Adjustment Amount	Claim Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2320 Loop
Claim Level Co-pay Amount	Claim Adjustment Amount	CAS* *3 Amounts 2320 Loop
Claim Level Deductible Amount	Claim Adjustment Amount	CAS* *1 Amounts 2320 Loop
Claim Level Coinsurance Amount	Claim Adjustment Amount	CAS* *2 Amounts 2320 Loop
Service Level Amount Paid	Service Line Amount Paid	SVD02 Amount Field 2430 Loop
Service Level Allowed Amount	Service Line Approved Amount	INST – Not Applicable PROF – AMT*AAE Amount 2400 Loop
Service Level Patient Responsibility Amount	Service Line Adjustment Amount	CAS*PR* Amounts 2430 Loop
Service Level Contractual Adjustment Amount	Service Line Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2430 Loop
Service Level Co-pay Amount	Service Line Adjustment Amount	CAS* *3 Amounts 2430 Loop
Service Level Deductible Amount	Service Line Adjustment Amount	CAS* *1 Amounts 2430 Loop
Service Level Coinsurance Amount	Service Line Adjustment Amount	CAS* *2 Amount s 2430 Loop
Second Tertiary Payer Name	Second Tertiary Payer Name	NM103 Field from 2010BB Loop or 2330B

		Loop
Second Tertiary Payer ID	Second Tertiary Payer ID	NM108 Field from 2010BB Loop or 2330B Loop
Claim Level Amount Paid	Other Payer Prior Payment - Actual Other Payer Amount Paid	INST – AMT*C4 Amount or AMT*N1 Amount 2320 Loop PROF – AMT*D Amount 2320 Loop
Claim Level Approved Amount	Other Payer Total Submitted Charges Other Payer Approved Amount	INST – AMT*T3 Amount 2320 Loop PROF – AMT*AAE Amount 2320 Loop
Claim Level Allowed Amount	Other Payer Allowed - Actual Other Payer Allowed - Actual	INST – AMT*B6 Amount 2320 Loop PROF – AMT*B6 Amount 2320 Loop
Claim Level Patient Responsibility Amount	Other Payer Patient Responsibility - Actual	INST – Not Applicable PROF – AMT*F2 Amount 2320 Loop
Claim Level Contractual Adjustment Amount	Claim Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2320 Loop
Claim Level Co-pay Amount	Claim Adjustment Amount	CAS* *3 Amounts 2320 Loop
Claim Level Deductible Amount	Claim Adjustment Amount	CAS* *1 Amounts 2320 Loop
Claim Level Coinsurance Amount	Claim Adjustment Amount	CAS* *2 Amounts 2320 Loop
Service Level Amount Paid	Service Line Amount Paid	SVD02 Amount Field 2430 Loop
Service Level Allowed Amount	Service Line Approved Amount	INST – Not Applicable PROF – AMT*AAE Amount 2400 Loop
Service Level Patient Responsibility Amount	Service Line Adjustment Amount	CAS*PR* Amounts 2430 Loop
Service Level Contractual Adjustment Amount	Service Line Adjustment Amount	CAS*CO* Amounts and/or CAS* *A2 Amounts 2430 Loop
Service Level Co-pay Amount	Service Line Adjustment Amount	CAS* *3 Amounts 2430 Loop
Service Level Deductible Amount	Service Line Adjustment Amount	CAS* *1 Amounts 2430 Loop
Service Level Coinsurance Amount	Service Line Adjustment Amount	CAS* *2 Amount s 2430 Loop

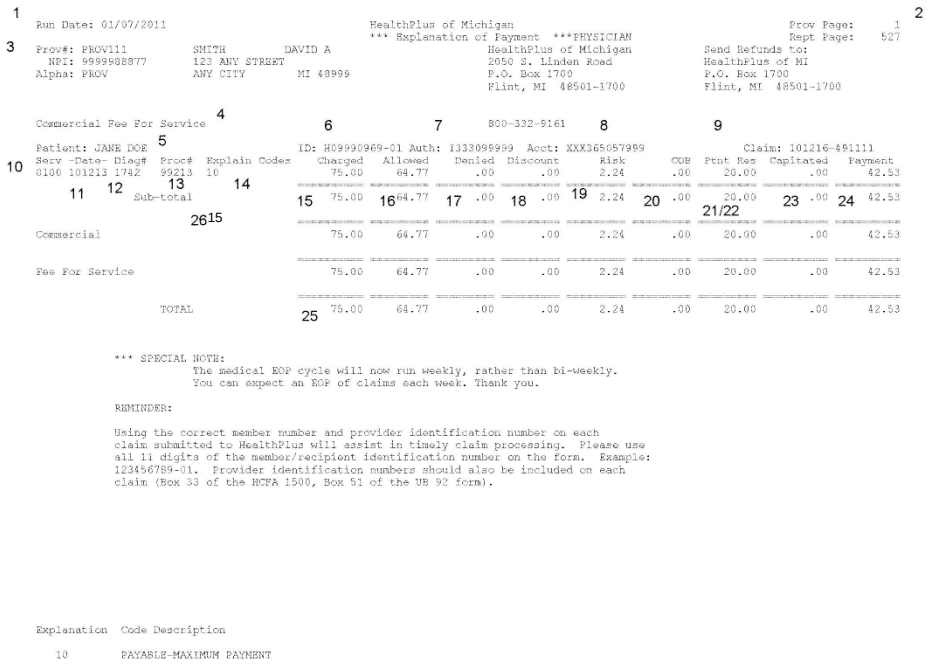
The HealthPlus Explanation of Payment (EOP) voucher reports claims that have been paid, denied or adjusted. Separate EOPs are issued for each line of business identifying the payer, i.e. HealthPlus of Michigan, HealthPlus Options, HealthPlus Partners (Medicaid), HealthPlus Insurance Company, etc.

The HealthPlus ancillary/organizational EOP is identified on the report as the "Institutional" EOP. All other providers of service will receive a "Physician" EOP report. HealthPlus has a weekly payment processing cycle for all providers. In certain instances, HealthPlus will pay a hospital on an interim basis. Interim payments are described on an Institutional EOP with "interim payment" noted. It is your responsibility to follow up on denied claims which appear on an EOP by reading the two-digit denied explain code and following the instructions, (i.e., correct patient information, obtain the appropriate referral, bill another carrier).

Note: Negative balances may result when a previously paid claim is adjusted back. Please make note of this occurrence, as the negative balance will continue to work itself off from future EOPs until cleared.

Physician EOP Explanation

The following explanations correspond with information shown on the Physician EOP:



1 2

Run Date: 01/07/2011 HealthPlus of Michigan Prov Page: 1
*** Explanation of Payment ***PHYSICIAN Rept Page: 527

3 Prov#: PROV111 SMITH DAVID A HealthPlus of Michigan Send Refunds to:
NPI: 9999988877 123 ANY STREET 2050 S. Linden Road HealthPlus of MI
Alpha: PROV ANY CITY MI 48999 P.O. Box 1700 P.O. Box 1700
Flint, MI 48501-1700 Flint, MI 48501-1700

4
Commercial Fee For Service 6 7 800-332-9161 8 9

5
Patient: JANE DOE ID: H09990969-01 Auth: I333099999 Acct: XXX365057999 Claim: 101216-491111

10 Servy	-Date-	Diag#	Proc#	Explain Codes	Charged	Allowed	Denied	Discount	Risk	COB	Pnt Res	Capitated	Payment
0100	101213	1742	99213	10	75.00	64.77	.00	.00	2.24	.00	20.00	.00	42.53
11 12 13 14 Sub-total					15 75.00	16 64.77	17 .00	18 .00	19 2.24	20 .00	21/22 20.00	23 .00	24 42.53
26 15 Commercial					75.00	64.77	.00	.00	2.24	.00	20.00	.00	42.53
Fee For Service					75.00	64.77	.00	.00	2.24	.00	20.00	.00	42.53
TOTAL					25 75.00	64.77	.00	.00	2.24	.00	20.00	.00	42.53

*** SPECIAL NOTE:
The medical EOP cycle will now run weekly, rather than bi-weekly.
You can expect an EOP of claims each week. Thank you.

REMINDER:

Using the correct member number and provider identification number on each claim submitted to HealthPlus will assist in timely claim processing. Please use all 11 digits of the member/recipient identification number on the form. Example: 123456789-01. Provider identification numbers should also be included on each claim (Box 33 of the HCFA 1500, Box 51 of the UB 92 form).

Explanation	Code Description
10	PAYABLE-MAXIMUM PAYMENT

1. Print date of EOP
2. Page number
3. Provider ID number, name and address
4. Category name report is a combination of line of business:

- Commercial
- Medicare Supplemental
- HealthPlus Medicare Advantage
- Medicaid
- Genesee Health Plan
- Saginaw Health Plan
- Bay Health Plan

and payment type:

[23]

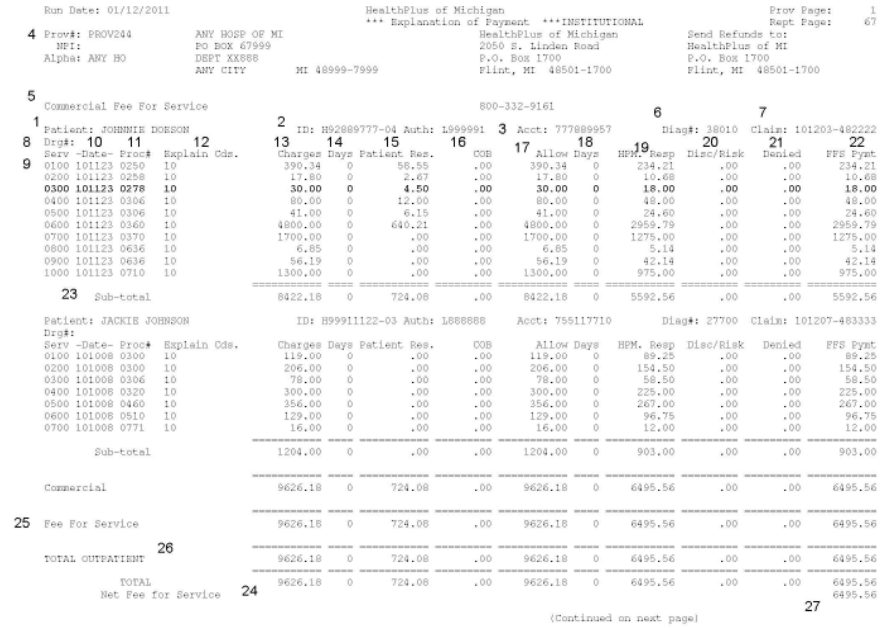
- Capitation
- Capitation adjustments
- Fee-for-service
- Fee-for service adjustments
- Denied
- Miscellaneous
- Pre-paid
- Pre-paid adjustments

5. Patient name
6. Patient HealthPlus identification number
7. HealthPlus referral or authorization number
8. Provider-assigned account number
9. HealthPlus claim number – the first six digits identify the date claim was received by HealthPlus
10. Service – identifies the individual service line on the claim
11. Date of service
12. Diagnosis code
13. Service/Procedure code
14. Explanation code
15. Fee charged
16. Allowable amount
17. Amount denied
18. Amount discounted
19. Amount of risk withheld
20. Third party payment by other carrier
21. Patient payment responsibility (i.e. copay, coinsurance, deductible, penalty)
22. Copay amount
23. Capitated (or interim) amount
24. Amount of payment
25. Total line
26. Subtotal line for the given section

The last page of the EOP report includes a "total" line, which reflects the section subtotals. The check issued by HealthPlus should equal the payment amounts in item 24.

Institutional EOP Explanation

The following explanations correspond with information shown on the Institutional EOP exhibit:



Run Date: 01/12/2011 — HealthPlus of Michigan — Prov Page: 1
*** Explanation of Payment ***INSTITUTIONAL — Rept Page: 67

4 Prov#: PROV244 — ANY HOSP OF MI — PO BOX 67999 — DEPT XX888 — ANY CITY MI 48999-7999
NPI:
Alpha: ANY HO

HealthPlus of Michigan — 2050 S. Linden Road — P.O. Box 1700 — Flint, MI 48501-1700

Send Refunds to: — HealthPlus of MI — P.O. Box 1700 — Flint, MI 48501-1700

5 Commercial Fee For Service — 800-332-9161

1 Patient: JOHNNIE DOBSON — 2 ID: H92889777-04 Auth: L999991 — 3 Acct: 777889957 — 6 Diag#: 38010 — 7 Claim: 101203-482222

8 Drg#: — 10 — 11 — 12 — 13 — 14 — 15 — 16 — 17 — 18 — 19 — 20 — 21 — 22

9

Serv -Date-	Proc#	Explain Cds.	Charges	Days	Patient Res.	COB	Allow	Days	HPM. Resp	Disc/Risk	Denied	FFS Pymt
0100 101123	0250	10	390.34	0	58.55	.00	390.34	0	234.21	.00	.00	234.21
0200 101123	0258	10	17.80	0	2.67	.00	17.80	0	10.68	.00	.00	10.68
0300 101123	**0278**	**10**	**30.00**	**0**	**4.50**	**.00**	**30.00**	**0**	**18.00**	**.00**	**.00**	**18.00**
0400 101123	0306	10	80.00	0	12.00	.00	80.00	0	48.00	.00	.00	48.00
0500 101123	0306	10	41.00	0	6.15	.00	41.00	0	24.60	.00	.00	24.60
0600 101123	0360	10	4800.00	0	640.21	.00	4800.00	0	2959.79	.00	.00	2959.79
0700 101123	0370	10	1700.00	0	.00	.00	1700.00	0	1275.00	.00	.00	1275.00
0800 101123	0636	10	6.85	0	.00	.00	6.85	0	5.14	.00	.00	5.14
0900 101123	0636	10	56.19	0	.00	.00	56.19	0	42.14	.00	.00	42.14
1000 101123	0710	10	1300.00	0	.00	.00	1300.00	0	975.00	.00	.00	975.00
23 Sub-total			8422.18	0	724.08	.00	8422.18	0	5592.56	.00	.00	5592.56

Patient: JACKIE JOHNSON — ID: H99911122-03 Auth: L888888 — Acct: 755117710 — Diag#: 27700 — Claim: 101207-483333
Drg#:

Serv -Date-	Proc#	Explain Cds.	Charges	Days	Patient Res.	COB	Allow	Days	HPM. Resp	Disc/Risk	Denied	FFS Pymt
0100 101008	0300	10	119.00	0	.00	.00	119.00	0	89.25	.00	.00	89.25
0200 101008	0300	10	206.00	0	.00	.00	206.00	0	154.50	.00	.00	154.50
0300 101008	0306	10	78.00	0	.00	.00	78.00	0	58.50	.00	.00	58.50
0400 101008	0320	10	300.00	0	.00	.00	300.00	0	225.00	.00	.00	225.00
0500 101008	0460	10	356.00	0	.00	.00	356.00	0	267.00	.00	.00	267.00
0600 101008	0510	10	129.00	0	.00	.00	129.00	0	96.75	.00	.00	96.75
0700 101008	0771	10	16.00	0	.00	.00	16.00	0	12.00	.00	.00	12.00
Sub-total			1204.00	0	.00	.00	1204.00	0	903.00	.00	.00	903.00
Commercial			9626.18	0	724.08	.00	9626.18	0	6495.56	.00	.00	6495.56
25 Fee For Service			9626.18	0	724.08	.00	9626.18	0	6495.56	.00	.00	6495.56
26 TOTAL OUTPATIENT			9626.18	0	724.08	.00	9626.18	0	6495.56	.00	.00	6495.56
TOTAL			9626.18	0	724.08	.00	9626.18	0	6495.56	.00	.00	6495.56
Net Fee for Service 24												6495.56

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(Continued on next page)

Run Date: 01/12/2011 — HealthPlus of Michigan — Prov Page: 2
*** Explanation of Payment ***INSTITUTIONAL — Rept Page: 68

Prov#: PROV244 — ANY HOSP OF MI — (Continued from previous page)
Commercial

REMINDER:

Using the correct member number and provider identification number on each claim submitted to HealthPlus will assist in timely claim processing. Please use all 11 digits of the member/recipient identification number on the form. Example: 123456789-01. Provider identification numbers should also be included on each claim (Box 33 of the HCFA 1500, Box 51 of the UB 92 form).

Explanation Code Description 28

10 PAYABLE-MAXIMUM PAYMENT

1. Patient name
2. Patient HealthPlus identification number
3. Account number assigned by provider
4. Provider ID number
5. Category name report is a combination of line of business:

   - Commercial
   - Medicare Supplemental

- HealthPlus Medicare Advantage
- Medicaid
- Genesee Health Plan
- Saginaw Health Plan
- Bay Health Plan

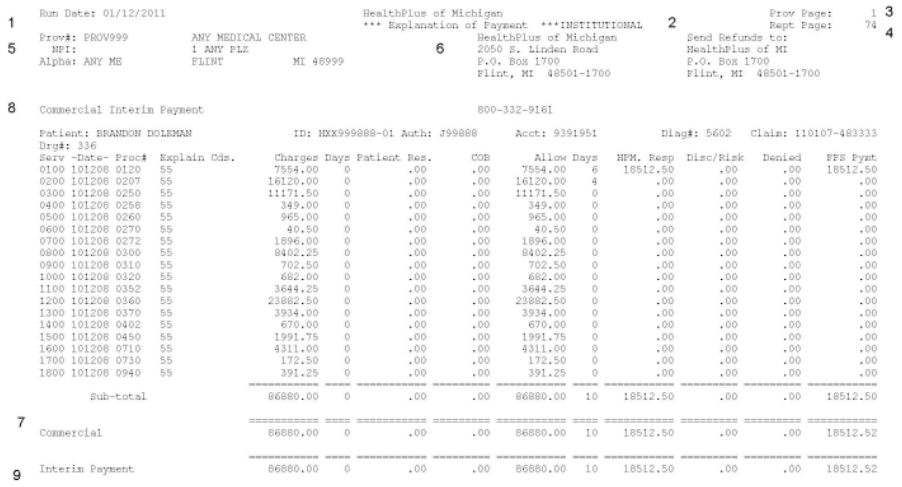
and payment type:

- Interim payment
- Interim payment adjustments
- Fee-for-service
- Fee-for service adjustments
- Denied
- Miscellaneous
- Interim payment
- Interim payment adjustments

6. Principal diagnosis code billed on claim
7. Claim number assigned by HealthPlus – the first six digits identify the date claim was received by HealthPlus
8. Reports the DRG number assigned by grouper
9. Identifies the individual service line on the claim
10. Date of service
11. Revenue code, CPT or HCPC procedure code
12. Explanation code
13. Amount charge by provider
14. Number of denied days billable to patient
15. Patient payment responsibility (i.e. copay, coinsurance, deductible, penalty)
16. Third party payment by other carrier
17. Charges minus the billable denied, and COB
18. Number of inpatient days
19. Allowed minus the billable denied code, COB, copay, coinsurance, deductible or penalty amounts
20. Discount plus risk withheld if applicable
21. Denied amount (that is not a billable denied)
22. Amount paid, or calculated interim payment
23. Totals column for each claim
24. Totals by categories
25. Sub-total for the given category
26. Total payable amount
27. Total amount of the FFS check
28. List of the explain code and descriptions on the EOP

Interim Institutional Explanation of Payments (EOP) Explanation

The following explanations correspond with information shown on the Interim Institutional EOP exhibit:



Run Date: 01/12/2011 — HealthPlus of Michigan — *** Explanation of Payment ***INSTITUTIONAL — Prov Page: 1 — Rept Page: 74

Prov#: PROV999 — ANY MEDICAL CENTER — NPI: — 1 ANY PLZ — Alpha: ANY ME — FLINT MI 48999

HealthPlus of Michigan — 2050 S. Linden Road — P.O. Box 1700 — Flint, MI 48501-1700

Send Refunds to: — HealthPlus of MI — P.O. Box 1700 — Flint, MI 48501-1700

Commercial Interim Payment — 800-332-9161

Patient: BRANDON DOLEMAN — ID: HXX999888-01 Auth: J99888 — Acct: 9391951 — Diag#: 5602 — Claim: 110107-483333 — Drg#: 336

Serv	-Date-	Proc#	Explain Cds.	Charges	Days	Patient Res.	COB	Allow	Days	HPM. Resp	Disc/Risk	Denied	FFS Pymt
0100	101208	0120	55	7554.00	0	.00	.00	7554.00	6	18512.50	.00	.00	18512.50
0200	101208	0207	55	16120.00	0	.00	.00	16120.00	4	.00	.00	.00	.00
0300	101208	0250	55	11171.50	0	.00	.00	11171.50	0	.00	.00	.00	.00
0400	101208	0258	55	349.00	0	.00	.00	349.00	0	.00	.00	.00	.00
0500	101208	0260	55	965.00	0	.00	.00	965.00	0	.00	.00	.00	.00
0600	101208	0270	55	40.50	0	.00	.00	40.50	0	.00	.00	.00	.00
0700	101208	0272	55	1896.00	0	.00	.00	1896.00	0	.00	.00	.00	.00
0800	101208	0300	55	8402.25	0	.00	.00	8402.25	0	.00	.00	.00	.00
0900	101208	0310	55	702.50	0	.00	.00	702.50	0	.00	.00	.00	.00
1000	101208	0320	55	682.00	0	.00	.00	682.00	0	.00	.00	.00	.00
1100	101208	0352	55	3644.25	0	.00	.00	3644.25	0	.00	.00	.00	.00
1200	101208	0360	55	23882.50	0	.00	.00	23882.50	0	.00	.00	.00	.00
1300	101208	0370	55	3934.00	0	.00	.00	3934.00	0	.00	.00	.00	.00
1400	101208	0402	55	670.00	0	.00	.00	670.00	0	.00	.00	.00	.00
1500	101208	0450	55	1991.75	0	.00	.00	1991.75	0	.00	.00	.00	.00
1600	101208	0710	55	4311.00	0	.00	.00	4311.00	0	.00	.00	.00	.00
1700	101208	0730	55	172.50	0	.00	.00	172.50	0	.00	.00	.00	.00
1800	101208	0940	55	391.25	0	.00	.00	391.25	0	.00	.00	.00	.00
	Sub-total			86880.00	0	.00	.00	86880.00	10	18512.50	.00	.00	18512.50
	Commercial			86880.00	0	.00	.00	86880.00	10	18512.50	.00	.00	18512.52
	Interim Payment			86880.00	0	.00	.00	86880.00	10	18512.50	.00	.00	18512.52

1. Production date of the EOP
2. Payer Name (i.e., HealthPlus of Michigan, HealthPlus Options, HealthPlus Partners)
3. Page number by provider
4. Page number of the report
5. Provider ID number, name and address
6. HealthPlus name and address
7. Line of business
8. Payment method – Interim
9. Interim payment – Total of all claims marked interim payment by category

The claims adjustment form can be found on our website in the *Provider* section at www.healthplus.org. This form can be printed off and submitted to the Claims Department for processing. Please use this form for incorrect payments only. Corrections to the original claim submission require that a corrected claim accompany the claims adjustment form.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process that determines the order in which health benefits are paid. COB also commonly includes other third party liability such as auto or homeowner's liability. COB guidelines are established by the National Association of Insurance Commissioners (NAIC), Medicare, Medicaid and Michigan law. In all instances, HealthPlus will pay only up to the HealthPlus fee schedule when combined with all other payment sources.

COB comes into play only when a claimant is covered under more than one group health plan, or has supplemental insurance such as homeowner's, business owner's, no-fault or workman's compensation. The process begins in the HealthPlus Liability and Recovery system when the COB staff "flags" any claim that may be a potential COB case. If necessary, the COB Department proceeds to gather the relevant facts and coordinate HealthPlus coverage with any other health or liability coverage the claimant may have.

HealthPlus COB representatives interact with doctors, nurses and office staff personnel, auto, homeowner's and other medical insurance companies and HealthPlus members to investigate and identify COB opportunities.

Providers are requested to assist HealthPlus in obtaining other coverage information and to bill services to the responsible primary insurer. For claims which may be related to an accident, injury or other coverage, please complete a COB Submissions Form.

Submit the COB form to:

HealthPlus of Michigan
COB Department
PO Box 1700
Flint, MI 48501-1700

If a HealthPlus member has primary insurance coverage through another carrier, or has another carrier with a deductible or copay required, the provider must submit the claim to the other carrier before billing HealthPlus. The exception to this is if the other carrier is traditional Blue Cross. You do not need to send an EOP from Blue Cross to HealthPlus for office visits and/or injections. You may bill HealthPlus first in these cases, even when the traditional Blue Cross policy is in effect. When HealthPlus is secondary, submit a copy of the Explanation of Payment (EOP) from the other carrier showing payment or denial of payment, along with a claim. The filing limit is calculated from the date on the other insurance's EOP voucher and not the date of service.

Medicaid COB Exceptions

If a HealthPlus Medicaid member has another insurance, HealthPlus Medicaid is always secondary. HealthPlus Medicaid will reimburse co-insurance and/or deductibles up to an amount that when combined with the other primary carrier payment, will not exceed the Medicaid maximum fee.

Background

When HealthPlus obtains information in regard to other coverage, we will properly coordinate benefits. It is imperative that the primary carrier(s) are billed first and then subsequently billed as secondary/tertiary to HealthPlus. In addition to the usual information requirements, the following additional fields will help expedite the processing of COB claims.

HealthPlus pays particular attention to the occurrence, value and condition codes detailed below. These are required, when applicable.

Occurrence Codes-Form locators 32-35a-b

HealthPlus requires the use of the following codes as instructed in the UB04 manual, when applicable:

01	Auto accident
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
04	Accident work related
05	Other accident
06	Crime victim
A2	Effective date – insured A policy
J1	Auto accident occurring outside the state of MI

Value Codes and Amounts-Form locators 39-41 a-b

HealthPlus requires the use of the following codes as instructed in the UB04 manual, when applicable:

13	ESRD beneficiary in the Medicare coordination period with an employer's group health plan
14	No fault (including auto/other)
15	Workers' compensation (including black lung)
41	Black lung
42	VA
43	Disabled beneficiary under age 65 with large group health plan
44	Amount provider agreed to accept from primary payer
47	Any liability insurance
67	Peritoneal dialysis
A1	Deductible Payer A
A2	Co-insurance payer A
A5	Covered Self-Administrable Drugs – Not Self-Administrable
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other
B1	Deductible payer B
B2	Co-insurance payer B
C1	Deductible payer C
C2	Co-insurance payer C
E1	Deductible payer D
E2	Co-insurance payer D
F1	Deductible payer E
F2	Co-insurance payer E

Condition Codes-Form locators 24-30

HealthPlus requires the use of the following codes as instructed in the UB04 manual, when applicable:

01	Military service
02	Condition is employment-related
03	Patient covered by insurance not reflected here
05	Lien has been filed
06	ESRD patient in first 30 months of entitlement covered by employer group health insurance
28	Patient and/or spouse EGHP secondary to Medicare covered by employer group health insurance
29	Disabled beneficiary and/or family member's large group health plan is secondary to Medicare
A0	Tricare external partnership program
A2	Physically handicapped children's program
07	Medicare secondary
08	Change Medicare primary payer
D7	Change - Medicare is secondary payer
D8	Change – Medicare is primary payer

Anesthesia

HealthPlus utilizes the Medicare methodology for anesthesia payments.

Medicare methodology includes:

- Use of anesthesia CPT codes (00100-01999)
- Use of the American Society of Anesthesiologists (ASA) 2001 Base Units
- Calculation of Incremental Time Units as opposed to Whole Time Units

Claims for all product lines must include the modifier, the anesthesia CPT code and the actual time, in minutes, for services performed.

The current modifiers will apply:

- AA Physician personally performs anesthesia service
- QK Physician medically directs 1 to 4 cases
- AD Physician medically supervises 4 cases
- QY Medical direction of 1 CRNA
- QX CRNA medically directed by physician
- QZ CRNA personally performs

Behavioral Health Modifiers

Claims submitted to HealthPlus for mental health and substance abuse outpatient counseling services require modifiers for correct payment:

- AH modifier: The service was performed by a psychologist (PhD, EdD)
- AJ modifier: The service was performed by a social worker or licensed professional counselor (MSW, CSW, ACSW, LLP, LPC)

Intake Assessments

Intake assessments performed by a PhD or MSW (CPT code 90801) can only be billed once within an approved authorization's date span. If a provider is given more than one authorization and/or referral for a patient during the member's benefit year, the provider can bill 90801 for each intake assessment per authorization.

Psychiatric Evaluations

In order for a psychiatrist (MD, DO) to receive payment for medication reviews (CPT code 90862), an intake assessment must have been provided.

Individual Therapy, Family Therapy and Group Therapy

Please be sure to bill the appropriate CPT code for individual, family or group therapy.

Practitioner ID Numbers

HealthPlus requires that all claims for behavioral health services include the individual practitioner's identification number. The only exception is the HealthPlus Partners capitated behavioral health program in the greater Flint region. Providers involved in that program should follow specific instructions provided by the capitated vendor.

Maternal & Infant Support Services

Maternal and infant support services (MSS/ISS) are specialized preventive services provided to pregnant women, mothers and infants to help reduce the infant's mortality and morbidity. These services are intended for HealthPlus Partners (Medicaid) members who are most likely to experience health problems due to psychological or nutritional conditions. These services must be provided by a State of Michigan certified MSS/ISS provider.

Authorization Process for Maternal Support Services

A HealthPlus Partners member can receive visits from an MSS/ISS provider with a referral. Approved providers include Family Independence Agencies, specialist providers and primary care physicians. HealthPlus Partners will only reimburse up to nine visits per pregnancy. Therefore, providers should confirm that the client has not received services through a different provider.

Authorization Process for Infant Support Services (ISS)

A HealthPlus Partners member can receive an initial assessment and six additional visits from an MSS/ISS provider without a referral. Approved providers include Family Independence Agencies, specialist providers and primary care physicians. After the initial assessment and three follow up visits have occurred, the following referral process is required:

- A completed "Continuation of Services" form
- A signed Physician Referral Form
- A copy of the initial assessment
- A plan of care

Requests for more than nine visits must include all of the above with the exception of the initial assessment. Approval is based upon assessed severity/complexity of issues on a case-by-case basis.

Immunizations

Reimbursement of an immunization for HealthPlus members consists of two components:

- Biological
- Administration

Both components must be billed to receive appropriate reimbursement.

Note: CPT guidelines have changed for billing the administration of multiple immunizations. It is now necessary to report both administration codes 90471 and 90472, with the appropriate quantities, when billing for more than one immunization.

Billing for both components

When billing the biological products for the Commercial and Medicaid product lines, use procedure codes 90476-90749. For biological products for the Medicare Advantage product line, use procedure codes 90658, 90659, 90660, 90669, 90703, 90718, 90732, 90746 and 90747. The appropriate administration codes for the Medicare Advantage product line include:

- G0008 for influenza
- G0009 for pneumonia
- G0010 for Hepatitis B

For all product lines, when billing for more than one immunization, report both administration codes 90471 and 90472 with the appropriate quantities.

Billing for Administration Only

When the biological has been obtained from the Health Department or is being billed by an outside supplier, the administration of the injection is billed alone. The biological must still be submitted for reporting purposes.

When reporting the biological products for the Commercial and Medicare Advantage product lines, use procedure codes 90676-90749 with modifier – 26. When reporting biological for the Medicaid product line, use the Vaccine Replacement Program procedure codes.

For all product lines, when billing for more than one immunization, report both administration codes 90471 and 90472 with the appropriate quantities.

Medicaid Vaccine Program

The following codes are to be billed when utilizing the Medicaid Vaccine Replacement (VFC) Program. Vaccines for children less than 19 years old:

- 90633 Hepatitis A – Pediatric
- 90655 Influenza - split 6-35 mos/preservative free
- 90657 Influenza - split 6-35 months
- 90658 + 3 years
- 90669 PCV7 Pneumococcal Conjugate under 5 yr
- 90700 DtaP
- 90701 DTP
- 90702 DT
- 90707 MMR
- 90713 Polio, IM
- 90716 Varicella
- 90718 TD
- 90721 DtaP-Hib
- 90723 DtaP-HepB-IVP
- 90645 Hib- (Hib titer)
- 90647 Hib- (Ped Vax)
- 90648 Hib- (ACT-Hib)
- 90732 PPV Pneumococcal – 3 + years
- 90744 Hepatitis B – Pediatric Polysaccharide
- 90748 Hep B-Hib

Note: Effective Jan. 1, 2006, the Michigan Vaccine Replacement Program (MI-VRP) for Medicaid beneficiaries ages 19 and older has been discontinued. Those vaccines remain available and are billable to HealthPlus. Payments are based upon the current Michigan Medicaid Fee Schedule for the following vaccines:

- 90632 Hepatitis A – Adult, im
- 90714 Td vaccine, no preserve > 7, im
- 90718 Td vaccine, > 7, im
- 90734 Meningococcal vaccine, im
- 90746 Hepatitis B – Adult
- 90747 Hepatitis B dialysis
- 90707 Poliovirus, ipv, sc

CODE	DESC
00	INFORMATIONAL - COB COURT ORDER RULE
01	PAYABLE - MEMBER SUBMITTED NOT VALID FOR DATE OF SERVICE, # CHANGED
02	INFORMATIONAL- PRIMARY POLICY HOLDER OF OTHER COVERAGE
03	INFORMATIONAL - COORDINATION DUE TO ESRD RULE
04	PAYABLE-PRORATED DRG DUE TO TRANSFER OR READMIT
05	INFORMATION-HPM IS PRIMARY FOR THIS PATIENT-OTHER CARRIER PAID IN ERROR
06	INFORMATIONAL – MEDICARE PRIMARY DUE TO DISABILITY
07	INFORMATIONAL - ESRD COORDINATION RULE, PAYOR OF LAST RESORT
08	PAYABLE-HPM THIRD PARTY LIABILITY REVIEWED
09	PAYABLE-BASED ON NPPN REPRICING-DISCOUNT QUESTIONS, CALL 800-557-1656
0A	INFORMATIONAL-COB BIRTHDAY RULE
0B	PAYABLE - COB REVIEW, PAID DEDUCTIBLE/COINSURANCE UP TO ALLOWED
0C	PAID-PRICED BY NPPN/AHI/HEALTHLINK 800-860-1111
0D	PAID-PRICED BY INTEGRATED HEALTH CARE MANAGEMENT-AMN 800-860-1111
0E	PAID-PRICED BY TRPN/MCS 800-860-1111
0F	PAID-PRICED BY INDIANAHN-PLUS MI 800-860-1111
0G	INFORMATIONAL-COB GENDER RULE
0H	PAID-PRICED BY IHP-FLHN 800-860-1111
0I	PAID-PRICED BY SOUTHCARE 800-860-1111
0J	PAID-PRICED BY HMA/RAN 800-860-1111
0K	PAID-PRICED BY IHP-MHN 800-860-1111
0L	PAID-PRICED BY IHP-HCP NETWORK 800-860-1111
0M	PAID-PRICED BY PHS (HPO/IHG) 800-860-1111
0N	PAID-PRICED BY MCS/PPONEXT NETWORK 800-860-1111
0P	PAID-PRICED BY PHS (VHN) NETWORK 800-860-1111
0Q	PAID-PRICED BY IHP-MR 800-860-1111
0R	PAID-PRICED BY IHP-NHN 800-860-1111
0S	PAID-PRICED BY CONCENTRA NETWORK 800-860-1111
0T	PAID-PRICED BY IHP-CHN 800-860-1111
0U	PAID-PRICED BY IHP-IHG 800-860-1111
0V	PAID-PRICED BY IHP-BEE 800-860-1111
0W	PAID-PRICED BY NPPN/PPONEXT 800-860-1111
0X	PAID-PRICED BY FIRSTHLTH 800-860-1111
0Y	PAID-PRICED BY IHP-FLORA HEALTH NETWORK 800-860-1111
0Z	PAID-PRICED BY TRPN/NPN CONTRACTUAL AGREEMENT 800-860-1111
10	PAYABLE-MAXIMUM PAYMENT
11	PAYABLE-FEE PAID PER MULTIPLE/BILATERAL SURGERY
12	PAYABLE-PRIVATE ROOM CHARGES REDUCED TO SEMI-PRIVATE
13	PAYABLE-PER CONSULTANT/TRIBUNAL REVIEW
14	PAYABLE-PROCEDURE OR REVENUE CODE ADDED OR CHANGED
15	PAYABLE - COB OTHER CARRIER NOT VALID FOR DATE OF SERVICE
16	PAYABLE-APPROVED-MEMBER SATISFACTION PLAN

17	PAYABLE-PHYSICIAN INCENTIVE INCLUDED
18	PAID-PRICED BY TRPN/HPO 800-860-1111
19	PAYABLE-PER NEGOTIATED RATE
1A	PAYABLE-PAID APC/ASC PRICING/MEDICARE FEE/MEDICAID FEE
1B	PAID-PRICED BY BEECH STREET NETWORK 800-860-1111
1C	PAYABLE-PAID/PPO DISCOUNT/IF QUESTIONS CALL 972-312-8589 - EXT 458
1D	ALLOWED AMOUNT MODIFIED UP TO THE PRIMARY CARRIER ALLOWED PER MI COB ACT
1E	PAID-PRICED BY BEECH STREET/BEST CARE NETWORK 800-860-1111
1F	PAID-PRICED BY BEECH STREET/AMCO NETWORK 800-860-1111
1G	PAYABLE-REIMBURSEMENT NEGOTIATED THROUGH GLOBAL CLAIMS SERVICES
1H	PAID-PRICED BY BEECH STREET/HEALTHCHOICE NAMCI NETWORK 800-860-1111
1I	PAID-PRICED BY BEECH STREET/INTER GROUP NETWORK 800-860-1111
1J	PAID-PRICED BY BEECH STREET/MIDLANDS CHOICE NETWORK 800-860-1111
1K	PAID-PRICED BY BEECH STREET/PHP NETWORK 800-860-1111
1L	PAID-PRICED BY BEECH ST/MANAGED HEALTHCARE NW NETWORK 800-860-1111
1M	PAID-PRICED BY BEECH STREET/PCN NETWORK 800-860-1111
1N	PAID-PRICED BY BEECH STREET/SIGNATURE NETWORK 800-860-1111
1P	PAYABLE-PER DIEM RATE
1Q	PAID PER CONTRACTUAL AGREEMENT
1R	PAID-PRICED BY BEECH STREET/IHC NETWORK 800-860-1111
1S	PAID-PRICED BY BEECH STREET/FIRST CHOICE NETWORK 800-860-1111
1T	PAID-PRICED BY BEECH STREET/SELECT NET PLUS NETWORK 800-860-1111
1U	PAID-PRICED BY BEECH STREET/AHC NETWORK 800-860-1111
1V	PAID-PRICED BY CCN NETWORK 800-860-1111
1W	PAID-PRICED BY CCN/FIRST CHOICE-SOUND HEALTH NETWORK 800-860-1111
1X	PAID-PRICED BY CCN/HCVM NETWORK 800-860-1111
1Y	PAID-PRICED BY EMERALD HEALTH NETWORK 800-860-1111
1Z	PAID-PRICED BY INDIANA HEALTH NETWORK 800-860-1111
20	PAYABLE-LATE FILING APPEAL APPROVED-FINAL DECISION
21	PAYABLE - SERVICES REVIEWED
22	PAYABLE-ADDITIONAL CHARGES OR CREDITS TO PREVIOUS CLAIM
23	PAYABLE-PAID AT DRG RATE
24	PAYABLE-CHARGES APPLIED TO RISK OR DISCOUNT - LIABILITY OF PROVIDER
25	PAYABLE-PAID PER MULTIPLAN PPO NEGOTIATED RATE
26	PAYABLE-PER INVOICE FOR PRICING OR AUDITING
27	PAYABLE-PAID PER NHBC PPO NEGOTIATED RATE
28	PAYABLE - PAYMENT REDUCED BY MEDICARE
29	PAYABLE-SERVICE MANUALLY PAID
2A	INFORMATIONAL-MEDICARE WORKING AGED TEFRA OBRA
2B	PAYABLE - MEDICAID'S REGULATION, PAYOR OF LAST RESORT
2C	DAILY DOLLAR LIMIT ALREADY MET
2D	PAYABLE-PAID AT MANAGED CARE MEDICAID / MEDICARE DRG RATE
2E	PAID-PRICED BY CONFINITY 800-860-1111
2F	PAID-PRICED BY TRPN 800-860-1111
2G	PAID-PRICED BY TRPN/IHP 800-860-1111
2H	PAYABLE-CHARGES COMBINED AND PROCEDURE PAID AT BILATERAL RATES
2I	IMMUNIZATION, FOR REPORTING PURPOSES ONLY
2J	PAID-PRICED BY MULTIPLAN 800-860-1111

2K	PAID-PRICED BY PPONEXT 800-860-1111
2L	PAID-PRICED BY NPPN 800-860-1111
2M	PAYABLE-MANAGED CARE MEDICAID/MEDICARE/CHP FEE SCHEDULE
2N	HEALTH ACCESS ENCOUNTER CLAIM ONLY
2O	PAID-PRICED BY HPO/MANAGED HEALTHCARE NW 800-860-1111
2P	PAID-PRICED BY UPUP/PRO-AMERICA 800-860-1111
2Q	PAID-PRICED BY NPPN/ACCOUNTABLE 800-860-1111
2R	PAID-PRICED BY NPPN/DIRECT 800-860-1111
2S	PAID-PRICED BY GALAXYHN 800-860-1111
2T	PAID-PRICED BY NPPN/MRI/PROV STRATEGIES 800-860-1111
2U	PAID-PRICED BY NPPN/NOVANET 800-860-1111
2V	PROVIDED THROUGH VACCINE REPLACEMENT/VACCINE FOR CHILDREN PROGRAM
2W	PAID-PRICED BY NPPN/HFN 800-860-1111
2X	PAID-PRICED BY NPPN/BAPTIST HEALTH SERVICES 800-860-1111
2Y	PAID-PRICED BY NPPN/INTERPLAN 800-860-1111
2Z	PAID-PRICED BY TRPN/PHS 800-860-1111
30	PAID-PRICED BY ELDORADO SERVICES GROUP NEGOTIATION 800-860-1111
31	PAID-PRICED BY NPPN/MRI/NATIONAL HOSP NETWORK 800-860-1111
32	PAID-PRICED BY NPPN/PHYSICIANS CARE NETWORK 800-860-1111
33	PAID-PRICED BY NPPN/TRPN 800-860-1111
34	PAID-PRICED BY NPPN/HEALTH MANAGEMENT ASSOC 1-800-860-1111
35	PAID-PRICED BY NPPN/OHIO PREFERRED NETWORK 1-800-860-1111
36	PAID-PRICED BY NPPN/ARIZONA MEDICAL NETWORK 800-860-1111
37	PAID-PRICED BY NPPN/FIRST CHOICE OF MIDWEST 800-860-1111
38	PAID-PRICED BY NPPN/PPOIN/PROHEALTH 800-860-1111
39	PAID-PRICED BY NPPN/SIGNATURE HEALTH ALLIANCE 800-860-1111
3A	PAID-PRICED BY NPPN/MEDICAL RESOURCE 800-860-1111
3B	PAID-PRICED BY TRPN/CCN 800-860-1111
3C	PAID-PRICED BY NPPN/MRI/GALAXY HEALTH NETWORK 800-860-1111
3D	PAID-PRICED BY NPPN/COMMUNITY HEALTH PARTNERS 800-860-1111
3E	PAID-PRICED BY TRPN/GALAXY 800-860-1111
3F	PAID-PRICED BY NPPN/AMERIAN PPO, INC. 800-860-1111
3G	PAID-PRICED BY NPPN/INTERGROUP 800-860-1111
3H	PAID-PRICED BY NPPN/QUALCHOICE OF ARKANSAS 800-860-1111
3I	PAID-PRICED BY NPPN/UNIVERSAL/NV 800-860-1111
3J	PAID-PRICED BY NPPN/SIGNATURE HEALTH ALLIANCE OF TENN 800-860-1111
3K	PAID-PRICED BY USAMCOFN 800-860-1111
3L	INFORMATIONAL - RETIRED MEDICARE PRIMARY
3M	INFORMATIONAL - RETIRED MEDICARE SECONDARY
3N	PAID-PRICED BY NPPN/AHI/UNICARE 800-860-1111
3O	PAID-PRICED BY NPPN/GALAXY HEALTH NETWORK 800-860-1111
3P	PAID-PRICED BY NPPN/PPO/KENTUCKY 800-860-1111
3Q	PAID-PRICED BY TRPN/FCHN 800-860-1111
3R	PAID-PRICED BY NPPN/HEALTH POINT PHYS. HOSP. ORG 800-860-1111
3S	PAID-PRICED BY NPPN/AMCARESCR 800-860-1111
3T	PAID-PRICED BY NPPN/TRPN-FORTIFIED PROV NETWORK 800-860-1111
3U	PAID-PRICED BY NPPN/BAYCARE 800-860-1111
3V	PAID-PRICED BY NPPN/UNIVERSAL/LA 800-860-1111
3W	PAID-PRICED BY IMSTEXAS NETWORK 800-860-1111
3X	PAID-PRICED BY NPPN/DIMENSION 800-860-1111

3Y	PAID-PRICED BY NPPN/RURAL ARIZONA 800-860-1111
3Z	PAID-PRICED BY NPPN/HEALTH PAYERS ORG(HPO) 800-860-1111
40	PAID-PRICED BY HMA 800-860-1111
41	PAID-PRICED BY NPPN/HEALTH SPAN NETWORK 800-860-1111
42	PAYABLE-PART D DRUG BENEFIT UNDER MEDICARE GUIDELINE
43	PAID-PRICED BY AMPSFEENEG 800-860-1111
44	PAID-PRICED BY NPPN/CHN/NJ 800-860-1111
45	PAID-PRICED BY NPPN/TPRN-MANAGED CARE STRAT NETWORK 800-860-1111
46	PAID-PRICED BY PRIMEHSPAS-PHS (PSI) NETWORK 800-860-1111
47	PAID-PRICED BY IMST TEXAS 800-860-1111
48	PAID-PRICED BY INTEGRATED HEALTH PLAN (IHPLAN) 800-860-1111
49	PAID-PRICED BY PRIME HEALTH 800-860-1111
4A	PAID-PRICED BY PRIMEHSPAS-PHS (FPN) 800-860-1111
4B	PAID-PRICED BY NPPN/INTERPLAN HEALTH GROUP 800-860-1111
4C	PAID-PRICED BY NPPN/THE INITIAL GROUP 800-860-1111
4D	PAID-PRICED BY NPPN/TRPN-PRIMARY HEALTH SERVICES 800-860-1111
4E	PAID-PRICED BY NPPN/AHI/UNICARE 800-860-1111
4F	PAID-PRICED BY PRIMEHSPAS 800-860-1111
4G	PAID-PRICED BY INTEGRATED HEALTH PLAN-HPO 800-860-1111
4H	PAID-PRICED BY INTEGRATED HEALTH PLAN-ghn 800-860-1111
4I	PAID-PRICED BY INTEGRATED HEALTH PLAN-ihp2 800-860-1111
4J	PAID-PRICED BY INTEGRATED HEALTH PLAN-NPN 800-860-1111
4K	PAID-PRICED BY INTEGRATED HEALTH PLAN-psi 800-860-1111
4L	PAID-PRICED BY INTEGRATED HEALTH PLAN-phn 800-860-1111
4M	PAID-PRICED BY INTEGRATED HEALTH PLAN-EC 800-860-1111
4N	PAID-DISCREPANT CHARGES PER NBAS AUDIT/PATIENT NOT RESPONSIBLE
4O	PAYABLE – PAID AT UAW RMBT CONTRACTED RATE
4P	PAYABLE-CLAIM PAID PER AUTHORIZED CODE NOT CODE BILLED
4Q	PAID-PRICED BY INTEGRATED HEALTH PLAN - PPON 800-860-1111
4R	PAID-PRICED BY INTEGRATED HEALTH PLAN-FOREMOST 800-860-1111
4S	PAID-PRICED BY INTEGRATED HEALTH PLANIHP 800-860-1111
4T	PAID-PRICED BY INTEGRATED HEALTH PLAN-FPN 800-860-1111
4U	PAID-PRICED BY TRPNAFFIL 800-860-1111
4V	PAID-PRICED BY TRPN/UHN 800-860-1111
4W	PAID-PRICED BY INTEGRATED HEALTHPLAN-PHS 800-860-1111
4X	PAID-PRICED BY PRIMEHSPAS-ART/NPN 800-860-1111
4Y	PAID-PRICED BY NPPN/AMERICAS PPO 800-860-1111
4Z	PAID-PRICED BY UPANDUP 800-860-1111
50	INFORMATIONAL- (PREPAID) - COB COURT ORDER RULE
51	PAYABLE (PREPAID)-APPROVED-MEMBER SATISFACTION PLAN
52	ADJUSTED (PREPAID) - THIRD PARTY COB PAYMENT / LIABILITY
53	PAYABLE (PREPAID)-FIXED RATE PER CONTRACT/DAILY DOLLAR LIMIT ALREADY MET
54	INFORMATIONAL- (PREPAID) - COB BIRTHDAY RULE
55	PAYABLE (PREPAID)-MAXIMUM PAYMENT
56	PAYABLE/ADJUSTED-(PREPAID) PER INT/EXT AUDIT
57	ADJUSTED (PREPAID)-PER CONTRACTUAL AGREEMENT/CORRECTION
58	INFORMATIONAL- LATE NOTIFICATION OF ADMISSION PENALTY APPLIED
5A	PAYABLE (PREPAID)-CLAIM PAID PER AUTHORIZED CODE NOT CODE BILLED
5B	PAYABLE (PREPAID) - PAID AT APC/MEDICARE/MEDICAID FEE
5C	ADJUSTED (PREPAID)-COPAYMENT

5D	ADJUSTED (PREPAID)-INCORRECT DATA/SEE CORRECTION
5E	ADJUSTED (PREPAID)-MEMBER/PARTICIPANT ELIGIBILITY
5F	PAYABLE - (CAPITATED) - MAXIMUM PAYMENT
5H	COB OBRA (PRE-PAID) MEDICARE PRIMARY
5I	ADJUSTED (PREPAID)-MAX PMT OR INTERNL DATA CORRECTION W/NO CHANGE IN PMT
5J	PAYABLE (PREPAID)-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
5K	ADJUSTED (PREPAID)-PAYMENT REDUCED DUE TO HOSPITAL ACQUIRED CONDITION
5L	ADJUSTED (PREPAID)-PER CONSULTANT REVIEW/APPEAL/MED AUDIT
5M	PAYABLE (PREPAID) PRORATED DRG DUE TO TRANSFER OR READMIT
5N	INFORMATIONAL-COB (PREPAID PPG) PAYOR OF LAST RESORT
5O	PAYABLE-COB (PREPAID PPG) PRIMARY POLICY HOLDER
5P	ADJUSTED (PREPAID)-DUPLICATE/SAME PROCEDURE PREVIOUSLY PAID
5Q	PAYABLE (CAPITATED)-FIXED RATE PER CONTRACT/DAILY $ LIMIT ALREADY MET
5R	ADJUSTED (PREPAID)-PER REFERRAL/AUTH POLICY
5S	ADJUSTED (PREPAID)-NO OTHER CARRIER LIABILITY
5T	PAYABLE (PREPAID)-REPLACED/REBUNDLED
5U	ADJUSTED (PREPAID)-ORIGINALLY PROCESSED TO INCORRECT PROVIDER/AFFIL
5V	ADJUSTED (PREPAID) - PERSONAL INJURY CASE/SUBROGATION/LEIN
5W	ADJUSTED (PREPAID)-INCORRECT BILLING VERIFIED BY HEALTHPLUS
5X	ADJUSTED (PREPAID)-CONTRACT CHG/CORRECTION/MBR RESPONSIBILITY DOES NOT CHANGE
5Y	INFORMATIONAL-COB (PREPAID PPG) ESRD MEDICARE PRIMARY
5Z	ADJUSTED (PREPAID)-PAID IN ERROR-OTHER COVERAGE LIABLE
60	INFORMATIONAL- (PREPAID - NON PPG)- COURT ORDER RULE
61	PAYABLE (PREPAID NON PPG)-APPROVED-MEMBER SATISFACTION PLAN
62	ADJUSTED (PREPAID-NON PPG)-THIRD PARTY COB PAYMENT / LIABILITY
63	PAYABLE (PREPAID-NON PPG)-FIXED RATE PER CONTRACT/DAILY $ LIMIT BEEN MET
64	INFORMATIONAL- (PREPAID - NON PPG) -COB BIRTHDAY RULE
65	PAYABLE (PREPAID NON PPG)-MAXIMUM PAYMENT
66	PAYABLE/ADJUSTED-(PREPAID-NON-PPG)PER INT/EXT AUDIT
67	ADJUSTED (PREPAID-NON PPG)-PER CONTRACTUAL AGREEMENT/CORRECTION
6A	PAYABLE (PREPAID NON PPG)-CLAIM PAID PER AUTHORIZED CODE NOT CODE BILLED
6B	PAYABLE (PREPAID NON-PPG) - PAID AT APC/MEDICARE/MEDICAID FEE
6C	ADJUSTED (PREPAID-NON PPG)-COPAYMENT
6D	ADJUSTED (PREPAID-NON PPG)-INCORRECT DATA/SEE CORRECTION
6E	ADJUSTED (PREPAID-NON PPG)-MEMBER/PARTICIPANT ELIGIBILITY
6G	INFORMATIONAL - (PREPAID NON PPG) PAYOR OF LAST RESORT
6H	COB (NON PPG) OBRA MEDICARE PRIMARY
6I	ADJUSTED (PREPAID-NON PPG)-MAX PMT OR INTERNL DATA CORR W/NO CHG IN PMT
6J	PAYABLE (PREPAID NON PPG)-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
6K	ADJUSTED (PREPAID NON-PPG)-PAYMT REDUCED DUE TO HOSP ACQUIRED CONDITION
6L	ADJUSTED (PREPAID-NON PPG)-PER CONSULTANT REVIEW/APPEAL/MED AUDIT

6M	PAYABLE (PREPAID-NON PPG) PRORATED DRG DUE TO TRANSFER OR READMIT
6N	EOB (NON PPG) ESRD MEDICARE PRIMARY
6P	ADJUSTED (PREPAID-NON PPG)-DUPLICATE/SAME PROCEDURE PREVIOUSLY PAID
6Q	PAYABLE (PREPAID NON PPG)-REPLACED/REBUNDLED
6R	ADJUSTED (PREPAID-NON PPG)-PER REFERRAL/AUTH POLICY
6S	ADJUSTED (PREPAID-NON PPG)-NOT OTHER CARRIER LIABILITY
6T	ADJUSTED (PREPAID-NON PPG)-REFUND RECEIVED RETRO ELIGIBILITY CHANGE
6U	ADJUSTED (PREPAID-NON PPG)-ORIGINALLY PROCESSED TO INCORRECT PROV/AFFIL
6V	ADJUSTED (PREPAID NON PPG)-PERSONAL INJURY CASE/SUBROGATION/LEIN
6W	ADJUSTED (PREPAID-NON PPG)-INCORRECT BILLING VERIFIED BY PROVIDER
6X	ADJUSTED (PREPAID-NON PPG)-CONTRACT CHG/CORRECTION/MBR RESPONSE DOES NOT CHG
6Y	COB (NON PPG) PRIMARY POLICY HOLDER
6Z	ADJUSTED (PREPAID NON PPG)-PAID IN ERROR-OTHER COVERAGE LIABLE
7D	ADJUSTED (NON-FFS)-DENIED - INCORRECT DATA - SEE CORRECTION
7J	ADJUSTED (NON-FFS)-DENIED-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
7K	ADJUSTED (PREPAID)-DENIED PAYMENT REDUCED DUE TO HOSP ACQUIRED CONDITION
7L	ADJUSTED (NON FFS)-DENIED-PER CONSULTANT REVIEW/APPEAL/MED AUDIT
7U	ADJUSTED (PREPAID)-DENIED-ORIGINALLY PROCESSED TO INCORRECT PROV/AFFIL
7W	ADJUSTED (NON FFS)-DENIED-INCORRECT BILLING VERIFIED BY HEALTHPLUS
7Z	ADJUSTED (NON FFS) DENIED - PAID IN ERROR, OTHER COVERAGE LIABILITY
8B	INFORMATIONAL - RETIRED MEDICARE PRIMARY
8C	INFORMATIONAL - RETIRED MEDICARE SECONDARY
8D	ADJUSTED (NON FFS-NON PPG)-DENIED - INCORRECT DATA - SEE CORRECTION
8J	ADJUSTED (NON-FFS/PPG)-DENIED-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
8K	ADJUSTED(PREPAY NONPPG)-DENIED PAYMT REDUCED DUE TO HOSP ACQUIRED CONDIT
8L	ADJUSTED (NON FFS-NON PPG)-DENIED-PER CONSULTANT REVIEW/APPEAL/MED AUDIT
8U	ADJUSTED (NON FFS-NON PPG)-ORIGINALLY PROCESSED TO INCORRECT PROV/AFFIL
8W	ADJUSTED (NON FFS-NON PPG)-DENIED-INCORRECT BILLING VERIFIED BY PROV
8X	ADJUSTED (NON FFS-NON PPG)-DENIED PRIVATE ROOM CHARGES
8Z	ADJUSTED (NON FFS NON PPG)DENIED-PAID IN ERROR,OTHER CARRIER LIABILITY
91	PAID-PRICED BY ONENET 800-860-1111
92	PAID-PRICED BY HYGEIA/FIRST HEALTH 800-860-1111
93	PAID-PRICED BY NPPN/Interplan Health Group-TX 800-860-1111
94	PAID-PRICED BY IHP/TLC 800-860-1111
95	PAID-PRICED THROUGH ONE OF THE GLOBALCARE NETWORKS
96	PAID-PRICED BY INDEPENDENT MEDICAL SYSTEMS 800-860-1111
97	PAID-TEXAS TRUE CHOICE 800-860-1111
98	PAID-PRICED BY IHP-DENTEMAX 800-860-1111
99	PAID-PRICED BY HEALTH PAYORS ORGANIZATION 800-860-1111

9A	PAID-PRICED BY IHP-NATIONAL HOSP NETWORK 800-860-1111
9B	PAID-PRICED BY IHP-RURAL ARIZONA NETWORK 800-860-1111
9C	PAID-PRICED BY NPPN/HPO/PRIMARY HEALTH SVCS. 800-860-1111
9D	PAID-PRICED BY DEVON HEALTH NETWORK 800-860-1111
9E	PAID-PRICED BY NPPN/PRIME HEALTH SERVICES 800-860-1111
9F	PRICED BY IHP-HFN 800-860-1111
9G	PAID-PRICED BY FORTIFIED PROVIDER NETWORK 800-860-1111
9H	PAID-PRICED BY HYGEIA 800-860-1111
9I	PAID-PRICED BY HPO/IHG 800-860-1111
9J	PAID-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
9K	PAID-PRICED BY NPPN/MEDICAL RESOURCE/NPPN 800-860-1111
9L	PAID-PRICED BY INTERPLAN HEALTH GROUP 800-860-1111
9M	PAID-PRICED BY PHCS HEALTHY DIRECTIONS 800-860-1111
9N	PAID-PRICED BYHMA/ARIZONA MEDICAL NETWORK 800-860-1111
9O	PAID-PRICED BY GLOBALCARE ARBITRATION 800-860-1111
9P	PAID-PRICED BY ENCORE HEALTH NETOWRK 800-860-1111
9Q	PAID-PRICED BY HMO/COMPETITIVE HEALTH NETWORK 800-860-1111
9R	PAID-PRICED BY NOVANET 800-860-1111
9U	PAYABLE-REPLACED/REBUNDLED
A3	ADJUSTED-REFUND RECEIVED-GMIS APPEAL OR AUDIT
A4	ADJUSTED-DRG AMOUNT PRORATED ACCORDING TO DAILY DRG RATE
A5	ADJUSTED-PER FACILITY PREAUTHORIZATION POLICY
A6	ADJUSTED-PROCEDURE CODE ADDED OR CHANGED
A7	ADJUSTED-DRG RATE
A8	ADJUSTED - NO MONEY RECEIVED, INTERNAL ADJUST ONLY
A9	ADJUSTED-REFUND RECEIVED
AA	ADJUSTED-DUPLICATE/SAME PROCEDURE PREVIOUSLY PAID
AB	ADJUSTED-ORIGINALLY PROCESSED TO INCORRECT PROVIDER / AFFILIATION
AC	ADJUSTED-COPAYMENT
AD	ADJUSTED-INCORRECT DATA-SEE CORRECTION
AE	ADJUSTED-MEMBER/PARTICIPANT ELIGIBILITY
AF	ADJUSTED-SERVICE NOT COVERED AS A BENEFIT OF MEMBERS CONTRACT
AG	ADJUSTED-PER CONSULTANT REVIEW/COB VENDOR
AI	ADJUSTED-MAX PAYMENT OR INTERNAL DATA CORRECTION W/NO CHANGE IN PAYMENT
AJ	ADJUSTED-DENIED-PAYMENT REDUCED DUE TO ACQUIRED CONDITION
AK	ADJUSTED-PAYMENT REDUCED DUE TO HOSPITAL ACQUIRED CONDITION
AL	ADJUSTED-PER CONSULTANT REVIEW/APPEAL/MED AUDIT
AM	ADJUSTED-PER CONTRACT CHANGE/CORRECTION/MBR RESPONSIBILITY DOES NOT CHG
AO	ADJUSTED-INCORRECT BILLING VERIFIED BY HEALTHPLUS
AP	ADJUSTED-PAID IN ERROR, MONEY RECOVERED FROM PROVIDER
AQ	ADJUSTED-PER CREDENTIALING POLICY
AR	ADJUSTED-PER REFERRAL/AUTH POLICY
AS	ADJUSTED-NOT OTHER CARRIER LIABILITY
AT	ADJUSTED-ERROR IN REPORTING OF SERVICE QUANTITY
AU	ADJUSTED-INCLUDED IN ANOTHER PROC/SERVICE OR PER CONTRACT
AW	ADJUSTED-PREVIOUSLY PROCESSED UNDER INCORRECT MEMBER/PARTICIPANT #
AX	ADJUSTED-PRIVATE ROOM CHARGE(S) POLICY
AY	ADJUSTED - PER NEGOTIATED AGREEMENT

AZ	ADJUSTED-PAID IN ERROR-OTHER CARRIER LIABILITY
B1	ADJUSTED- THIRD PARTY COB PAYMENT RECEIVED
B2	ADJUSTED-THIRD PARTY COB PAYMENT TO PROVIDER
B7	ADJUSTED-PER CONTRACTUAL AGREEMENT/CORRECTION
B8	ADJUSTED-PER LATE FILING APPEAL COMMITTEE
B9	ADJUSTED-ANOTHER ADMISSION REIMBURSED AT STANDARD DRG RATE METHODOLOGY
BA	ADJUSTED-APPROVED PER MEMBER SATISFACTION
BB	ADJUSTED-CLAIM REVIEWED/APPEAL APPROVED
BC	ADJUSTED-BALANCE TO CONTRACT/ORIGINALLY PAID HPM RATES TO PROVIDER
BH	ADJUSTED-FEE REDUCED-MULTIPLE/BILATERAL SURGERY
BI	ADJUSTED-ACCORDING TO HPO NEGOTIATED AGREEMENT
BJ	AUTO ADJUSTED - PER CONTRACTUAL AGREEMENT
BT	ADJUSTED-REFUND RECEIVED-RETRO ELIGIBILITY CHANGE
BV	ADJUSTED-PERSONAL INJURY CASE/SUBROGATION/LEIN
C1	PAID-PRICED BY IHP-PRIME HEALTH SERVICES 800-860-1111
C2	PAID-PRICED BY IHP-UNIVERSAL HEALTH NETWORK 800-860-1111
C3	PAID-PRICED BY THE INITIAL GROUP 800-860-1111
C4	PAID-PRICED BY IHP-IGS 800-860-1111
C5	PAID-PRICED BY VIANT NEGOTIATED RATE 800-860-1111
C6	PAID-PRICED BY CORVEL 800-860-1111
C7	PAID-PRICED BY HEALTHEOS 800-860-1111
C8	PAID-PRICED BY NPPN/DENTEMAX 800-860-1111
C9	PAID-PRICED BY NPPN/COALITION AMERICAN (CAD) 800-860-1111
CA	PAID-PRICED BY SIGNATURE HEALTH ALLIANCE 800-860-1111
CB	PAID-PRICED BY PSI 800-860-1111
CC	PAID-PRICED BY NPPN/USA MCO 800-860-1111
CD	PAID-PRICED BY HPO/PRIMARY HEALTH SERVICES 800-860-1111
CE	PAID-PRICED BY NPPN/PLANCARE AMERICA (PCA) 800-860-1111
CF	PAID-PRICED BY INTERGROUP SERVICES CORP 800-860-1111
CG	PAID-PRICED BY MULTIPLAN/VIANT NEGOTIATION 800-860-1111
CH	PAID-PRICED BY DEVON FEE NEGOTIATION 800-860-1111
CZ	INFORMATIONAL-DEPENDENT OF PRIMARY POLICY
D0	DENIED-CONSENT FORM PROCEDURE NOT FOLLOWED
D1	DENIED-PROVIDER RESPONSIBLE FOR COST OF SERVICE
D2	OTHER CARRIER PAID MAXIMUM ALLOWED - NO PATIENT LIABILITY
D3	DENIED-BILL THE SECONDARY CARRIER-HPM IS TERTIARY
D4	DENIED-REFERRAL REQUIRED/NOT IN PLACE FOR SVCS BILLED-MEMBER RESPONSIBLE
D5	DENIED-AUTH INVALID FOR PROCEDURE/DIAGNOSIS/SURGERY OR LOCATION REPORTED
D6	DENIED-AUTHORIZATION NOT ISSUED BY MEMBER'S PRIMARY PHYSICIAN
D7	DENIED-BENEFIT COVERED BY COMMUNITY MENTAL HEALTH OR STATE MEDICAID
D8	DENIED-FACILITY SERVICES NOT AUTHORIZED-MEMBER LIABILITY
D9	DENIED-ADMISSION DEEMED RELATED, RESUBMIT CORRECTED COMBINED CLAIM
DA	DENIED-IMAGE DESTROYED - PLEASE REBILL
DB	DENIED-SERVICE NOT PAYABLE BASED ON INFORMATION RECEIVED
DC	DENIED-NOT PAYABLE PER PROVIDER CONTRACT

DD	DENIED-MEMBER INELIGIBLE ON DATE OF SERVICE
DE	DENIED-SERVICES FOR THIS VISION DIAGNOSIS ARE NOT PAYABLE
DF	DENIED-FACILITY SVCS NOT AUTHORIZED OR MEMBER NOT ELIG ON DATE OF ADMIT
DG	DENIED-BILL COMPLETE INPATIENT SPAN, INCLUDING LEAVE DAYS, AS ONE
DH	DENIED-ADMISSION REPORTED EXCEEDS DAYS AUTHORIZED
DI	DENIED-SERVICE, PROCEDURE OR DIAGNOSIS NOT PAYABLE
DJ	DENIED-PATIENT NAME AND CONTRACT # REPORTED DO NOT AGREE
DK	DENIED-BEYOND CONTRACT FILING PERIOD FOR CLAIM
DL	DENIED-CODE NOT APPROPRIATE FOR SERV BILLED OR LACKS SUPPORTING HCPC/CPT
DM	DENIED-PERIOD OF CARE/# OF SERVICES OMITTED ON CLAIM OR APPEAR INCORRECT
DN	DENIED-SERVICE NOT COVERED AS A BENEFIT OF MEMBER'S CONTRACT
DO	DENIED-FACILITY SRVS NOT AUTHORIZED-MEMBER NOT RESPONSIBLE FOR CHARGES
DP	DENIED-PROCEDURE NOT PAYABLE IN LOCATION REPORTED
DQ	DENIED-PROCEDURE BILLED REQUIRES APPROVED CREDENTIALS
DR	DENIED-PER MEDICAL CONSULTANT OR PEER REVIEW
DS	PROCEDURE NOT REIMBURSED SEPARATELY
DT	DENIED-DOESN'T MEET RADIOLOGY MEDICAL NECESSITY-PROVIDER RESPONSIBLE
DU	DENIED-SAME PROCEDURE PREVIOUSLY PAID
DV	DENIED-ITEMIZATION, INVOICE, DOCUMENTATION OR ELECTRONIC REMARK NEEDED
DW	DENIED-MAXIMUM SERVICES PREVIOUSLY PROVIDED
DX	DENIED-PROCEDURE CODE NOT PAYABLE OR INVALID FOR DIAGNOSIS REPORTED
DY	DENIED-RENTAL/MAINTENANCE NOT PAYABLE FOR DME ITEM
DZ	DENIED-SERVICES MUST BE OBTAINED FROM CONTRACTING PROVIDER
E0	DENIED-CLAIM LACKS CHARGES FOR SERVICES
E1	DENIED-WORKERS COMPENSATION LIABLE
E2	DENIED-OTHER COVERAGE LIABLE
E3	DENIED-AUTO COVERAGE LIABLE
E4	DENIED - INACTIVE PROVIDER#, USE ACTIVE PROVIDER#
E5	DENIED-CLAIM LACKS CORRECT PATIENT NAME AND/OR BIRTH DATE
E6	DENIED-MEMBER NAME/NUMBER REPORTED UNKNOWN/NEWBORN NOT ENROLLED
E7	DENIED-LOCATION OF SERVICE NOT REPORTED OR APPEARS INCORRECT
E8	DENIED-DATE OF SERVICE NOT REPORTED OR APPEARS INCORRECT
E9	DENIED-ICD9 DIAG/PROC CODE MISSING OR INVALID
EA	DENIED - INCORRECT OR MISSING HPM PROVIDER NUMBER BILLED
EB	DENIED-NOT BILLING ACCORDING TO STANDARDIZED BILLING GUIDELINES
EC	CHARGES APPLIED TO COPAY/COINSURANCE/DEDUCTIBLE-LIABILITY OF MEMBER
ED	DENIED-A8,A9 VALUE CODES REQUIRED FOR ESRD PRICING
EE	DENIED-PROCEDURE MODIFIER NOT REPORTED OR APPEARS INCORRECT
EF	DENIED-CLAIM LACKS ADMITTING OR REFERRING PHYSICIAN NAME
EG	DENIED-INCLUDED IN PREVIOUS SETTLEMENT
EH	DENIED-PROCEDURE CODE ISN'T VALID-REBILL WITH CORRECT CODE
EI	DENIED-CHARGES APPEAR TO INDICATE ERROR IN BILLING

EJ	DENIED-NETWORK REVIEW ALLOWS ZERO DUE TO MUTUALLY EXCLUSIVE RULE
EK	DENIED-SERVICE INAPPROPRIATE FOR PATIENT GENDER
EL	DENIED-MASTER MEDICAL VOUCHER REQUIRED
EM	DENIED-SERVICE INAPPROPRIATE FOR PATIENT AGE
EN	DENIED-PART D BENEFIT-MBR RESPONSIBLE BUT CAN SUBMIT FOR REIMBURSEMENT
EO	DENIED-DED/CO-PAY/VALUE CODE AND/OR PAY REPORTED IS MISSING OR INCORRECT
EP	DENIED-MEMBER HAS NOT SELECTED PCP ON D.O.S./HAS DIFFERENT PCP ON D.O.S.
EQ	DENIED-PROCEDURE/MODIFIER BILLED AND QUANTITY MUST CORRESPOND
ER	DENIED-ANESTHESIA TIME NOT REPORTED IN MINUTES/OR APPREARS INCORRECT
ES	DENIED-ANOTHER CLAIM IS IN PROCESS
ET	DENIED-DIAGNOSIS INAPPROPRIATE FOR PATIENT GENDER
EU	DENIED-NO ORIGINAL CLM TO ATTACH LATE CHARGES, ADJ OR REPLACEMENT CLM TO
EV	DENIED-OTHER COVERAGE LIABLE-PERSONAL INJURY CASE
EW	DENIED-BREAKDOWN OF DATES AND/OR CHARGES REQUIRED FOR CORRECT PROCESSING
EX	DENIED-LATE NOTIFICATION OF ADMISSION
EY	DENIED-DISCREPANCY BETWEEN COB VOUCHER SUBMITTED & CLAIM
EZ	DENIED-OTHER CARRIER VOUCHER REQUIRED
F0	DENIED-ONLY PAYABLE WHEN PERFORMED BY PCP
F1	DENIED-NO PRIOR AUTH ON FILE/RADIOLOGY SERVICE - PROVIDER RESPONSIBILITY
F2	DENIED - ISDA CRITERIA NOT MET FOR PRE-OP DAY
F3	DENIED - ISDA CRITERIA FOR SERVICE(S) NOT MET
F4	DENIED-REFERRAL EXISTS, BUT THE VISITS HAVE BEEN USED
F5	DENIED-HEALTHPLUS IS NO LONGER THE INSURANCE CARRIER-CONTACT EMPLOYER
F6	DENIED-ICD9 PROCEDURE OR CPT CODE MISSING OR APPEARS INCORRECT
F7	DENIED-SERVICE REQUIRES DRS ORDER, NDC# & DOSAGE/NDC# IS INVALID
F8	DENIED - LATE CHARGES NOT ALLOWED - BILL REPLACEMENT CLAIM
F9	RENTAL PAYMENT EQUALS OR EXCEEDS PURCHASE PRICE OR PREVIOUSLY PURCHASED
FA	DENIED - MAX MAINTENANCE PREVIOUSLY PAID / NOT PAYABLE ON PURCHASED ITEM
FB	DENIED-SALES TAX NOT PAYABLE DUE TO NON-PROFIT STATUS
FC	DENIED-RUG/CMG CODE REQUIRED BUT NOT SUPPLIED ON BILL
FD	DENIED-NO VALID AUTHORIZATION TO ORDERING PHYSICIAN FOR DATE OF SERVICE
FE	DENIED-AUTHORIZATION DENIED, SERVICES AVAILABLE IN-PLAN
FF	DENIED-INCORRECT BILLING - VERIFIED BY HEALTHPLUS
FG	DENIED-TECHNICAL SURGICAL ASSISTANT NOT ALLOWED FOR THIS SERVICE
FH	DENIED-MEMBER SUFFIX IS MISSING OR APPEARS INCORRECT
FI	DENIED-INPATIENT AUTHORIZATION INVALID-PATIENT NOT ADMITTED
FJ	DENIED-NUMBER OF SERVICES BILLED DON'T CORRESPOND WITH DATES
FK	DENIED-REFERRAL LACKS MEDICAL INFORMATION NECESSARY FOR REVIEW
FL	NOT REIMBURSABLE-SERVICE LINE ERROR PER APC OUTPATIENT CODE EDITOR
FM	INFORMATION COLLECTED FOR QUALITY IMPROVEMENT ACTIVITIES

FN	CHARGES CAPTURED FOR INFORMATIONAL PURPOSE ONLY
FO	DENIED-BILL JVHL (JOINT VENTURE HOSPITAL LABORATORIES)
FP	DENIED-NPI BILLED DOES NOT MATCH NPI/TAXONOMY ON RECORD
FQ	DENIED-INCLUDED IN ANOTHER PROCEDURE OR SERVICE
FR	DENIED - DUE TO AN EXTERNAL AUDIT A REPLACEMENT CLAIM CANNOT BE BILLED
FS	DENIED-MEMBER MUST FILE FOR MEDICARE PER MEDICAID COMPLIANCE
FT	NO PATIENT LIABILITY-PRIMARY INS PAYMENT = OR EXCEEDS HPM ALLOWED AMT
FV	DENIED-INCLUDED IN FACILITY DRG OR PER DIEM PAYMENT
FW	DENIED-THIS SURGERY PROC CODE NOT PAYABLE IN THIS LOCATION PER POLICY
FX	DENIED-PARTIAL SERVICES NOT COVERED
FY	DENIED-COUNTY HEALTH PLAN DOES NOT COORDINATE. HPM IS NOT RESPONSIBLE
FZ	DENIED - PER APC OUTPATIENT CODE EDITOR
G0	DENIED- INVALID/BLANK POA BILLED
G1	DENIED-MEMBER NOT ELIGIBLE FOR FULL SPAN-REPORT SPECIFIC DATE OF SERVICE
G2	DENIED - TYPE OF BILL ERROR
G3	DENIED - REBILL OTHER CARRIER - ADDITIONAL INFORMATION REQUIRED
G4	DENIED-REFERRAL EXISTS BUT VISITS USED/RADIOLOGY-PROVIDER RESPONSIBILITY
G5	DENIED-MEDICARE WILL SEND CROSSOVER CLAIM TO HPM ELECTRONICALLY
G6	DENIED-NO FEE ISSUED BY MEDICAID OR CODE NOT PAYABLE BY MEDICAID
G7	DENIED - REPORT OTHER CARRIER PAYMENT AND REBILL ELECTRONICALLY
G8	DENIED-INSUFFICIENT OTHER INS PAYMENT INFO-REBILL PAPER CLAIM W/ VOUCHER
G9	DENIED - PREVIOUSLY PAID THROUGH CAPITATION
GA	DENIED-CODE NOT AUTHED BY CARECORE, SEE ADDED SERVICE LINE FOR PAYMENT
GB	DENIED-HEALTHPLUS PAID PRIMARY
GC	DENIED-PREVIOUSLY PROCESSED/DIFFERENT PROVIDER# SAME/DIFFERENT ADDRESS
GD	DENIED-SVCS MUST BE OBTAINED BY CONTRACTING PROVIDER-CALL/1-800-332-9161
GE	DENIED-SERVICING PROVIDER SHOULD BILL HPM DIRECTLY--NOT THROUGH VSP
GF	DENIED-MEMBER CONTRACT# CHANGED - NEW AUTHORIZATION NEEDED
GG	DENIED-BILL TO THE APPROPRIATE MEDICARE CARRIER FIRST
GH	DENIED-ALL CLAIMS DENY DUE TO NO MEMBER RESPONSE TO COB INQUIRY
GI	DENIED-REFERRAL EXISTS, BUT VISITS USED/RADIOLOGY/MEMBER RESPONSIBILITY
GJ	DENIED-THIS PROCEDURE IS ONLY PAYABLE THROUGH THE PHARMACY SYSTEM
GK	DENIED-MEDICARE DENIED THIS SERVICE - REFER TO MEDICARE EOMB CODE
GL	DENIED-CLAIM REVIEW-INCLUDED IN GLOBAL SURGICAL FEE
GM	DENIED-MEDICARE HAS FULL RESPONSIBILITY FOR THIS SERVICE
GN	DENIED-RESUBMIT CLAIM WITH MEDICARE'S ORIGINAL PAYMENT/DENIAL
GO	DENIED-MODIFIER APPEARS INCORRECT, ITEM PREVIOUSLY PURCHASED
GP	MEDICARE PAID SERVICE IN FULL
GQ	DENIED - MEMBER RESPONSIBLE FOR MEDICARE COINSURANCE

GR	DENIED- PROCEDURE NOT INDICATED FOR SEPARATE REIMBURSEMENT
GS	DENIED-CLAIM REVIEW-SERVICE INAPPROPRIATE FOR PATIENT GENDER
GT	DENIED-CLAIM REVIEW-SERVICE INAPPROPRIATE FOR PATIENT AGE
GU	DENIED-ASK HOSP CONTRACT MGR/POSSIBLE PAY UNDER GHP PREPD HOSP AGREEMENT
GV	DENIED-COURT ORDERED TREATMENT NOT COVERED
GW	DENIED-PROCEDURE MUTUALLY EXCLUSIVE TO ANOTHER PROCEDURE
GX	DENIED-INCIDENTAL PROCEDURE NOT PAYABLE
GY	DENIED- PROCEDURE REBUNDLED TO ANOTHER PROCEDURE
GZ	DENIED-BILL MDCH DIRECTLY FOR THESE PROCEDURE CODES
H1	DENIED-PROV. TERMINATED DUE TO LICENSE REVOCATION
H2	DENIED-BILL QUEST (CAP ARRANGEMENT-SHP & BHP EFF 2/14/09)
H3	DENIED-TIN/ADDRESS DOESN'T MATCH HPM RECORD-CHANGE FORM REQUIRED
H4	DENIED-RUG'S/CMG/HIPPS CODE REQUIRED
H5	DENIED-PREGNANCY-RELATED SERVICES ARE NOT A COVERED BENEFIT
H6	DENIED-PRIOR AUTH REQ; NOT IN PLACE FOR SERV BILLED, MEMBER RESPONSIBLE
H7	DENIED-PRIOR AUTH REQ; NOT IN PLACE FOR SERV BILLED, PROVIDER RESPONSIBLE
H8	DENIED-PRIOR AUTH; CRITERIA NOT MET, MEMBER RESPONSIBLE
H9	DENIED-PRIOR AUTH; CRITERIA NOT MET, PROVIDER RESPONSIBLE
HB	DENIED-OTHR CARRIER DETERMINES THIS SERVICE NOT PAYABLE REFER TO VOUCHER
HC	DENIED-ADD ON CODE NOT PAYABLE WHEN BILLED ALONE
HD	DENIED-BILL GENESEE COUNTY HEALTH DEPARTMENT/BCCCP
HE	DENIED-SAME PROCEDURE PREVIOUSLY PAID
HF	DENIED-ITEMIZATION, INVOICE, DOCUMENTATION/ELECTRONIC REMARK NEEDED
HG	DENIED-PROCEDURE/MODIFIER BILLED AND QUANTITY MUST CORRESPOND
HH	DENIED-SEVERITY CODE MISSING/INCORRECT
HI	DENIED-EPISODE TIMING MISSING/INCORRECT
HJ	DENIED-PART D VACCINE MEMBER ONLY RESPONSIBLE FOR HPM ALLOWED AMT
HK	DENIED-SOURCE CODE MISSING/INCORRECT
HM	DENIED-NOT PAYABLE TO YOUR PROVIDER SPECIALTY
HN	DENIED-SRV PROVIDED BY A NON-PAR MEDICARE PROV. SRV NOT COVERED
HO	DENIED-INVALID PROC/MODIFIER COMBINATION
HP	DENIED-INCLUDED IN ANOTHER PROCEDURE OR SERVICE
HQ	DENIED-PROCEDURE MUTUALLY EXCLUSIVE TO ANOTHER PROCEDURE
HR	DENIED-CURRENT LINE REPLACED BY NEW LINE W/MOD 51 ADDED/REMOVED
J0	PAID-PRICED BY INTEGRATED HEALTH PLAN-MMPP 800-860-1111
J1	PAID-PRICED BY NPPN/INTERWEST-TRADITIONAL 800-860-1111
J2	PAID-PRICED BY IHP-ARIZONA MEDICAL NETWORK 800-860-1111
J3	PAID-PRICED BY INTEGRATED HEALTH CARE MANAGEMENT 800-860-1111
J4	PAID-PRICED BY PRIMEHSPAS-HMN 800-860-1111
J5	PAID-PRICED BY PRIMEHSPAS-PSI 800-860-1111
J6	PAID-PRICED BY PRIMEHSPAS-IHP-HPO 800-860-1111
J7	PAID-PRICED BY NPPN/HPO/INTEGRATED HLTH PLAN 800-860-1111
J8	PAID-PRICED BY INTEGRATED HEALTH PLAN-PHS1 800-860-1111
J9	PAID-PRICED BY PRIMEHSPAS-PHS(HPO) 800-860-1111
JA	PAID-PRICED BY INTEGRATED HEALTH PLAN-NHP 800-860-1111

JB	PAID-PRICED BY INTEGRATED HEALTH PLAN-HCD 800-860-1111
JC	PAID-PRICED BY TRPNDIRECT 800-860-1111
JD	PAID-PRICED BY HFN20 800-860-1111
JE	PAID-PRICED BY IHP-BEECHSTREET 800-860-1111
JF	PAID-PRICED BY IHP-EVOLUTIONS HEALTH SYSTEM 800-860-1111
JG	PAID-PRICED BY IHP-INTERPLAN HEALTH GROUP NETWORK 800-860-1111
JH	PAID-PRICED BY NPPN/ACCOUNTABLE HEALTH PLAN 800-860-1111
JI	PAID-PRICED BY PRIME HEALTH SERVICES EOB 800-860-1111
JJ	PAID-PRICED BY PHS(HPO) PRIME HEALTH - HPO 800-860-1111
JK	PAID-PRICED BY TRPN/HFN 800-860-1111
JL	PAID-PRICED BY THREE RIVERS AFFILIATE 800-860-1111
JM	PAID-PRICED BY NPPN/MRI/NATIONAL PROV NETWORK-800-860-1111
JN	PAID-PRICED BY PHS(PSI) 800-860-1111
JO	PAID-PRICED BY IHP HEALTH FIRST NETWORK 800-860-1111
JP	PAID-PRICED BY NPPN/PREFERRED MENTAL HLTHNTWK/800-860-1111
JQ	PAID-PRICED BY PHS(CCO) 800-860-1111
JR	PAID-PRICED BY TRPN/MCS/PPONEXT 800-860-1111
JS	PAID-PRICED BY PHS 800-860-1111
JT	PAID-PRICED BY HMA/HMN 800-860-1111
JU	PAID-PRICED BY IHP-FORTIFIED PROVIDER NTWK 800-860-1111
JV	PAID-PRICED BY HFN 800-860-1111
JW	PAID-PRICED BY THREE RIVERS PROVIDER NETWORK/MCS/PPONEXT 800-860-1111
JX	PAID-PRICED BY NPPN AC 800-860-1111
JY	PAID-PRICED BY IHP-HEALTH MANAGEMENT NETWORK 800-860-1111
JZ	PAID-PRICED BY HPO/MIDWEST MEDICAL PROVIDERS 800-860-1111
P0	PENDED-DRG RATE FILE ERROR
P1	PENDED-PROCEDURE REQUIRES APPROVAL BY MEDICAL DIVISION
P2	PENDED-REVIEW BY SKILLED CARE/CASE MANAGEMENT SERVICES
P3	PENDED-REVIEW FOR RATE 1 C PROCEDURE
P4	PENDED-REVIEW OF CLAIMCHECK EDIT BY CLAIMS DEPT
P5	PENDED-RESEARCH OF REFERRAL INFORMATION BY CLAIMS
P6	PENDED-REVIEW OF CODING OR FURTHER RESEARCH BY CLAIMS DEPT
P7	PENDED-REVIEW FOR COORDINATION OF BENEFITS
P8	PENDED-REVIEW OF ELIGIBILITY BY ENROLLMENT
P9	PENDED-REVIEW OF AUTHORIZATION DATA BY MEDICAL DIVISION
PA	PENDED-GENESYS PRICING/SURGERIES WITH NO FEE/CLAIM GOES TO DISCOUNT
PB	PENDED-DME REVIEW
PC	PENDED-CLAIMS DEPT PROVIDER REVIEW
PD	PENDED-REVIEW OF DOCUMENTATION BY BEHAVIORAL HEALTH DEPARTMENT
PE	PENDED-REVIEW OF NEWBORN ENROLLMENT/ELIGIBILITY
PF	PENDED-REVIEW REFERRING PROVIDER HAS BEEN TERMED
PG	PENDED-PNM GLOBALCARE STATUS CHANGE
PH	PENDED-REQUIRES PHARMACY PRICING
PI	PENDED-NPI-PROVIDER CONFIGURATION REVIEW
PJ	PENDED – REVIEW BY CLAIM SUPPORT TEAM AND/OR GLOBALCARE
PK	PENDED - REVIEW ICD-9 PROC CODE FOR PPG RECIPROCITY
PL	PENDED-REPLACEMENT CLAIM
PM	PENDED-SERVICE NEEDS ILLNESS (CI) CODE OF D5/DME SIX POINT PLAN PRICING

PN	PENDED-REVIEW FOR DRG OR DAILY DRG PAYMENT
PO	PENDED-TPP AMT/VOUCHER APPLIED, NO OTHER COVERAGE LOADED
PP	PENDED-QUALITY ASSURANCE REVIEW
PQ	PENDED-CLAIMS DEPT REVIEW OF REFERRAL/AUTHORIZATION REQUIRED
PR	PENDED - NPPN PRICING
PS	PENDED-A & G FINANCIAL PRICING
PT	PENDED-COST OR HI-DAY OUTLIER REVIEW
PU	PENDED-RESEARCH OCCURRENCE, VALUE OR CONDITION CODE REPORTED AS LIABILITY
PV	PENDED-REVIEW BY SBM/UR OFFICE
PW	PENDED-RESEARCHING FOR WORKMENS COMP LIABILITY
PX	PENDED-COVERAGE CHANGE DURING PERIOD OF CONFINEMENT
PY	PENDED-GLOBAL CLAIMS SERVICES PRICING
PZ	PENDED-ADJUSTORS HOLDING TEMPORARILY FOR FURTHER INFORMATION
S0	PENDED-PROVIDER WILL NEGOTIATE DIRECTLY W/HPM ON A CASE BY CASE BASIS
S1	PENDED-PEND TEAM REVIEW
S2	PENDED-REVIEW BY INSURANCE SERVICES SPECIALIST/CLAIMS DEPT
S3	PENDED-BENEFIT LIMIT REVIEW
S4	PENDED-POSSIBLE DUPLICATE
S5	PENDED- REQUIRES REVIEW FOR INVOICE
S6	PENDED-RESEARCHING FOR OTHER HEALTH INSURANCE
S7	PENDED-REQUIRES FILING PERIOD REVIEW
S8	PENDED-TAX ID# DOES NOT MATCH HPM PIN#
S9	PENDED-DENTAL CLAIM REQUIRING REPORT OR X-RAY
SA	PENDED-PROVIDER ON REVIEW, MEDICAL AUDIT
SB	PENDED-RESEARCHING DIVORCE DECREE OR COURT ORDER
SC	PENDED-INPATIENT REHAB OR SNF REQUIRES PRICING
SD	PENDED-NEW ENROLLEE-PRE-EXIST CONDITION REVIEW (GLS)
SE	PENDED-DRG# IS REQUIRED FOR DRG PRICING
SF	PENDED-TOTAL NUMBER OF DAYS EXCEED THE COVERAGE PERIOD
SG	PENDED-MICROFILM NEEDED TO PROPERLY PROCESS CLAIM
SH	PENDED-POSSIBLE INCORRECT PROVIDER NUMBER ENTERED
SI	PENDED-REFERRAL REQUIRED TO ORDERING/ADMITTING PHYSICIAN
SJ	PENDED-CASE MANAGEMENT REVIEW
SK	NO APC/FEE SCHEDULE ON FILE OR INVALID PAYMENT STATUS
SL	PENDED-FACILITY FIXED RATE
SM	PENDED-IS CONFIG TEAM-REVIEW BENEFIT CONFIGURATION
SN	PENDED-PROVIDER ON REVIEW PEND CLAIM TO ADJUSTORS
SO	PENDED-CASE MANAGEMENT REVIEW-SBM
SP	PENDED-CLAIMS DEPT REVIEW-CHECK LOC, CI, CORRECT PROVIDER, ETC.
SQ	PENDED-INCORRECT MODIFIER/CAUSE OF ILLNESS FOR CLAIM
SR	PENDED-HPM DUAL-PROCESS COPAY/DEDUCT ON 2ND ID OR ADD/EDIT HPM RECORD
SS	PENDED-REQUIRES RESEARCH BY CLAIMS DEPARTMENT
ST	PENDED-DME FOR REVIEW - TCR BENEFIT SPECIALIST
SU	PENDED-REQUIRES RESEARCH BY PROVIDER SERVICES (SBM)
SV	PENDED - NEEDS RESOLUTION BY EDI TEAM LEADER
SW	PENDED-RESEARCH NEEDED BY PROVIDER SVCS SPECIALIST COORDINATOR
SX	PENDED-REQUIRES PEND AND EDIT REVIEW
SY	PENDED-REQUIRES RESEARCH BY INSURANCE SERVICES DIRECTOR OR AUDIT

	MANAGER
SZ	PENDED-CLAIM REQUIRES DEVELOPMENT OR ADDITIONAL INFORMATION
T0	PENDED-OTHER INSURANCE INFORMATION SHOULD BE CHANGED OR TERMINATED
T1	PENDED-PNM PROVIDER REVIEW
T2	PENDED-DRG# BILLED DIFFERENT THAN DRG# ASSIGNED BY DRG GROUPER
T3	PENDED-REVIEW BY PROVIDER SERVICES DEPT (GLS)
T4	WARNING-POSSIBLE FIXED FEE SURG/TIER ER/OBSER UNIT PERDIEM
T5	WARNING - ROUTE TO SUPERVISOR TO CHECK FOR UNIT PRICE
T6	PENDED-RESEARCHING FOR MOTOR VEHICLE LIABILITY
T7	PENDED-INJURY DIAGNOSIS REVIEW FOR THIRD PARTY LIABILITY
T8	PENDED-REQUIRES REVIEW FOR HOSPICE COVERAGE
T9	PENDED-REVIEW OF BILLED CHARGES FOR APPROPRIATENESS
TA	PENDED-HEALTHPLUS PARTNERS AUTHORIZATION REVIEW
TB	WARNING - REFER TO MODIFIER MATRIX CHART
TC	PENDED-RESEARCHING FOR OTHER PARTY LIABILITY
TD	PENDED-NEW ENROLLEE-PRE-EXIST CONDITION REVIEW (SBM)
TE	PENDED-MODIFIER PRICING OR REVIEW
TF	PENDED-REVIEW OF ELIGIBILITY BY ENROLLMENT/AR
TG	AUTO RECOMMENDED TO CASE MANAGEMENT (DUE TO TOTAL DOLLAR LIMIT ON CLAIM)
TH	WARNING-AUTH REQ'D TO ORDERING/ADMITTING PHYSICIAN
TI	PENDED - PRE-NEGOTIATED AGREEMENT - SEE REMARK
TJ	AUTO RECOMMENDED TO CASE MGMT (DUE TO DX/LOC/PROC) INFO ONLY - AUTH'S
TK	PENDED-RESEARCHING INJURY DIAGNOSIS FOR LIABILITY
TL	PENDED - REVIEW OF PROVIDER / ON-CALL SITUATION
TM	PENDED-RESEARCHING FOR MEDICARE PRIMARY INSURANCE
TN	WARNING - FACILITY CLAIM - USE MOTHER'S ID# FOR BABY
TO	STAT 18 ADJUSTMENT UNKNOWN EXPLAIN CODE
TP	PENDED-MULTIPLAN PRICING
TQ	PENDED-GFR-MED DIRECTOR REVIEW-COSMETIC/MEDICAL NECESSITY
TR	WARNING - PROCESS ON RX SIDE
TS	PEND-DUAL HPM COVERAGE - PROCESS UNDER PRIMARY HPM ID#
TT	PENDED-NO OTHER INSURANCE RECORD & CLAIM HAS ATTACHED VOUCHER OR REMARK
TU	PENDED-INACTIVE AFFILIATION RESEARCH BY MEDICAL MANAGEMENT
TV	PENDED-TCR-MED DIRECTOR REVIEW-COSMETIC/MEDICAL NECESSITY
TW	PENDED-IS CONFIGURATION
TX	PENDED - REQUIRE RESEARCH BY MEDICAID DIRECTOR
TY	PENDED - REVIEW BY SAGINAW MARKETING DEPARTMENT
TZ	PENDED-MULTIPLE SVC PROVIDER AFFILIATIONS QUALIFY (ERROR#CLCLS012005)
V	VOID OTHER
V1	VOID – OTHER
V9	DENIED-MULTI-UNIT LINE DENIED FOR MORE THAN ONE REASON
VA	VOID ADJUSTMENT
VL	VOIDED - ADVANCE METPATH LABORATORY
VM	VOIDED - NOT A CLAIM BUT A STATEMENT SENT BY MEMBER
VN	VOID CLAIM NUMBER
VP	VOID PHARMACY CLAIM

VQ	VOIDED - LATE CHARGES ADDED TO ORIGINAL CLAIM
VR	VOID-CLAIM RETURNED TO PROVIDER-INCORRECT BILLING
VS	VOID STATUS CLAIM
VV	VOID-UNREPORTED ADJUSTMENT LINE
VZ	VOID-ANESTHESIA CLAIM RETURNED TO PROVIDER-INCORRECT BILLING
W0	PENDED-RESEARCH OF CARECORE REFERRAL FOR OB ULTRASOUND PROCEDURES
W1	PENDED-SURGERY CUTS-APPLY Z MODIFIERS
W2	WARNING-CHECK MEMBER CONTRACT SPANS - SPLIT CLAIM IF APPROPRIATE
W3	PENDED -TIME UNITS REQUIRED WITH ANESTHESIA MODIFIER
W4	PEND-RUN CLAIM THRU DESKTOP PRICER
W5	PENDED-ERROR BETWEEN AMISYS AND CLAIMCHECK – USE RVTP TO RESET CLM
W6	WARNING-SEE INDICATOR REMARK OR AUTH REMARK FOR INSTRUCTIONS
W7	PENDED FOR REVIEW OF EOMB CODE
W8	WARNING-IF INVOICE ATTACHED, USE MODIFIER PC
W9	PENDED - TAX IDENTIFICATION NUMBER NEEDED ON W9 FORM
WA	PENDED-INTERNAL PEND, RSET CLAIM FOR EXACT MESSAGE
WB	PENDED-REVIEW FOR GLOBAL SURGICAL POLICY
WC	PENDED-INTERNAL PEND-MULTIPLE AUTHS APPLY - PLEASE CHOOSE APPROPRIATELY
WD	WARNING-ICD9 PROCEDURE FOR USE ON INPAT HEADER ONLY - NOT SERVICE LINE
WE	PENDED-RESEARCH AND APPLY APPROPRIATE COPAY IF NEEDED
WF	WARNING-INDIVIDUAL ANTEPARTUM CARE REQUIRES REVIEW
WG	PENDED - PCP AFFILIATION NOT FOUND
WH	PENDED - PCP IS NOT EFFECTIVE AT TIME OF SERVICE
WI	PENDED - THE MEMBER DOES NOT HAVE A MEMBER-SPAN RECORD
WJ	PENDED-RESEARCH TO BE DONE BY REFERENCE AND CONTROL COMMITTEE
WK	PENDED - FOR APC GROUPING
WL	PENDED - OUTPATIENT CLAIM EDIT PRIOR TO APC GROUPING
WM	PENDED-PEND TO MEDICAL AUDIT FOR MEMBER ON REVIEW
WN	PENDED-PEND AND EDIT TEAM REVIEW
WO	PENDED-TO DETERMINE IF PROVIDER IS IN GLOBALCARE NETWORK
WP	PENDED-VERIFY PROV#, MODIFIER, ETC TO DETERMINE ENTRY ERROR AND CORRECT
WQ	PENDED- PENDED FOR NETWORK REVIEW
WR	PENDED-APPLY HENRY FORD BARIATRIC ALL INCLUSIVE OR DRG RATE
WS	PENDED FOR INPATIENT PPS PRICING
WT	PENDED-PHARMACY REVIEW FOR INJECTABLE VS PHARMACY
WU	PENDED-PEND SPEC CONFIRM PROC REC'D PRIOR APPR'L BY PLAN MED DIRECTOR
WV	PENDED-RESEARCH FOR CARECORE REFERRAL--REPLACE THE AUTOMATED REFERRAL
WW	PENDED-IS CONFIGURATION PRICING
WX	PENDED-HISTORICAL CLAIM CHECK EDIT (SEE REMARK)
WY	WARNING-DATE OF SERVICE PRIOR TO 1/1/93-REMOVE CI CODE
WZ	WARNING-HOSP CLM-CI CODE OF Z8 OR Z7 NEEDED BASED ON MEDICARE VOUCHER
XC	ADJUSTED-DENIED OTHER CARRIER PAYMENT EXCEEDS MEDICAID ALLOWABLE AMOUNT

XD	ADJUSTED-DENIED-INCORRECT DATA - SEE CORRECTION
XG	ADJUSTED-DENIED-PER CONSULTANT REVIEW/COB VENDOR
XL	ADJUSTED-DENIED-PER CONSULTANT REVIEW/APPEAL/MED AUDIT
XO	ADJUSTED-DENIED-INCORRECT BILLING VERIFIED BY HEALTHPLUS
XR	ADJUSTED-DENIED-REFUND REQUESTED BY ADJUSTOR TEAM
XW	ADJUSTED-DENIED-PREV PROCESSED UNDER INCORRECT MEMBER/PARTICIPANT #
XZ	ADJ-DENIED-PAID IN ERROR-OTHER CARRIER LIABLE-NO REFUND REC'D FROM PROV
Y1	ADJUSTED-DENIED-NOT ELIGIBLE ON DATE OF SERVICE - MEMBER LIABLE
YB	ADJUSTED-DENIED-ORIGINALLY PROCESSED TO INCORRECT PROVIDER/AFFILIATITION
YM	DENIED-SERVICES REVERSED BY MEDIMPACT

Question	Answer	Additional Information
What do I do if I have a claim denied where I disagree and the denial has an "explain" code of GL, GR, GS, GT, GW, GX or GY?	Send a written appeal to: HealthPlus of Michigan Attn: Medical Audit Dept. PO Box 1700 Flint, MI 48501	Include operative report, if applicable, and/or any supporting documentation necessary.
If I get a claim denied that requires supporting documentation, where do I send the information?	Rebill the claim with notation in the "remark" section and attach the required documents.	The paper claim will receive special handling and be processed using the supporting documentation.
What if I have a claim denied where I disagree and the denial has an "explain" code other than those listed above?	Send a written appeal to: HealthPlus of Michigan Attn: Claims Dept. PO Box 1700 Flint, MI 48501	Include operative report, if applicable, and/or supporting documentation necessary.
What is the filing period for claims submission?	Providers are encouraged to submit all claims within 60 days from the date of service, but in all events to submit to HealthPlus all claims for covered services within one year of the date of service or hospital inpatient discharge.	
Can I file an adjustment electronically?	There is a link on our website that allows providers to submit an adjustment electronically or print off the adjustment form and mail it in with the corrected claim(s).	www.healthplus.org.
What do I do to appeal a late filing denial?	Providers must submit an appeal within six months of the date of denial. Please include cover letter, a copy of the EOP voucher and all documentation of timely submission.	Send a written appeal to: HealthPlus of Michigan Attn: PNM Dept. PO Box 1700 Flint, MI 48501

What if my electronic claims submission is not accepted by HealthPlus? How do I retrieve my electronic acceptance report? Who do I call when I have other electronic claims questions?	Contact an EDI Specialist	HealthPlus Claims Department: (810) 230-2084 or 1-800-332-9161
What do I do if I've submitted a hard copy claim but haven't received payment or rejection within 60 days?	Verify the claim form has been completely filled out. Use the website to see if the claim is in process.	Do not print "Status Inquiry" or "Resubmission" on claim forms. www.healthplus.org.
What do I do if I've received an EOP with denied claims?	The explanation of the two-digit denial codes gives you information for the correct billing process. Obtain the necessary information and rebill with the appropriate remarks.	