Alberta Health Claims Submission Explanation Codes

01 NOT REGISTERED
01 We have no record of this person registered with this Personal Health Number.

01A NOT REGISTERED
01A This person is not registered under the Alberta Health Care Insurance Plan.
01A If the patient is a newborn, submit a new claim with a person data segment and the appropriate newborn code.

01B NON RESIDENT
01B We cannot confirm that this patient is a resident of Alberta. Please contact the patient to obtain the correct billing information.

01C GOOD FAITH CLAIM
01C Payment has been refused as:
01C a) A Good Faith claim was previously paid for this patient; therefore, this patient does not qualify for further Good Faith claim processing, or
01C b) Good Faith claims are not payable for visitors to Alberta or for residents covered by the federal government, such as RCMP, Canadian Forces members or inmates in federal corrections facilities.
01C Refer to the practitioner resource guide for information regarding your billing alternatives.

02 REGISTRATION NUMBER/PHN CONFLICT
02 The Health Registration Number and the Personal Health Number (PHN) used are not for the same person.

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

04 DONOR’S REGISTRATION NUMBER USED
04 Submit this claim using the Personal Health Number of the donor recipient.

04A CHANGED PERSONAL HEALTH NUMBER
04A This is the correct Personal Health Number for this patient. All new claims for this patient should be submitted with this number.

05 PATIENT PERSONAL HEALTH NUMBER - NOT EFFECTIVE
05 This Personal Health Number is not effective for the date(s) of service.

05A INVALID PERSONAL HEALTH NUMBER
05A The Personal Health Number is invalid or blank.

05AA OPTED OUT RESIDENTS
05AA The patient has opted out of the Alberta Health Care Insurance Plan. The patient has agreed to assume financial liability for all health services.
05AA Please contact your patient regarding payment for your services.

05B UNREGISTERED WCB CLAIM
05B The patient is not eligible for Alberta Health Care coverage for the date(s)
05B of service. Submit your claim directly to the Workers' Compensation Board.

05BA INVALID/BLANK REGISTRATION NUMBER
05BA This claim has been refused as the registration number is:
05BA (a) blank
05BA (b) invalid

05BB INVALID/BLANK ULI
05BB This claim has been refused as the Unique Lifetime Identifier is:
05BB (a) blank
05BB (b) invalid
05BB (c) not a valid ULI for the Service Recipient

05C ELIGIBILITY EXTENDED HEALTH BENEFITS PROGRAM
05C The patient did not have coverage under the Extended Health Benefit (EHB) program on this date.
05C Effective April 1, 2002, to be eligible for EHB the patient must be a recipient of the Alberta Widows’ Pension or their dependant.
05C If your patient does not fit this description, benefits will be refused.
05C If the patient needs more information, contact Customer service and Registration Branch at (780)427-1432.

05E E.H.B. COVERAGE
05E Payment has been refused as the service(s) were provided when the patient did not have coverage under the Extended Health Benefits Program.

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

07 NEW RECIPIENT FOR ALTERNATIVE PAYMENT PLAN CONTRACT
07 Your claim for a new recipient was paid as a fee for service benefit.

08 NEW RECIPIENT PREVIOUSLY PAID FOR APP CONTRACT
08 Payment was refused as a fee for service claim was previously paid for a new recipient.

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

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

10A SERVICE PROVIDER RESTRICTIONS
10A Our records indicate that the Service Provider is:
10A (a) restricted to a specific Facility or
10A (b) restricted to performing specific services.

10AA INELIGIBLE PRACTITIONER
10AA This claim has been refused as you are not entitled to payment for this type of service.
LOCUM BUSINESS ARRANGEMENT
This claim has been refused as the Business Arrangement does not include a Business Arrangement Type of Locum.

INELIGIBLE SERVICES
Payment was refused as the services are not covered in the Schedule of Benefits. The services include:
Advice by Telephone
Ambulance Service
Anaesthetic Materials
Cosmetic Services
Drugs/Agents
Medical and Surgical Appliances and Supplies
Medical Testimony in Court
Oculo-visual/Optometric services for residents age 19 through 64 years (For dates of service on or after December 1, 1994)
Secretarial or Reporting Fees
Stand by Time
Tinted Glasses (EHB)
Travel Time
Refer to the General Rule 3 in the Schedule of Medical Benefits or General Rule 5.1 in the Schedule of Oral and Maxillofacial Surgery Benefits.

THIRD PARTY SERVICES
Examinations or services required to provide reports or certificates requested by a third party are not an insured service, eg:
Adoption Judicial Purposes
Attendance at Camp (examinations/procedures
Autopsies requested by police)
Employment Motor Vehicle License (except
Insurance/disability after the age of 74.5 years of age)
Family & Social Services Participation in Sports
University or other school Passport or Visa
entrance Immigration Requirements

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

R.C.M.P., ARMED FORCES AND FEDERAL PENITENTIARY
Members of the RCMP, Armed Services and inmates of a Federal Penitentiary are not beneficiaries under the Plan.

PRACTITIONER BILLING FOR OWN FAMILY
Services provided to members of your family or yourself are not a benefit under the Plan.

DENTAL CARE - ORAL SURGERY
This service is not an oral surgical procedure payable by the Plan.

BENEFIT GUIDE
This is an incorrect Health Service Code. Please refer to the Plan's appropriate fee schedule.
20F EXCLUDED ITEM
20F This service is not payable under the Extended Health Benefits Program.

21 WORKERS' COMPENSATION BOARD CLAIM
21 This claim is the responsibility of the Workers' Compensation Board.

21A PAYMENT RESPONSIBILITY/BENEFIT CODE
21A The payment responsibility (Workers' Compensation Board or Alberta Health Care) and Health Service Code submitted do not agree. Verify the responsibility and submit a new claim.

21AA WORKERS' COMPENSATION BOARD - PATIENT OVER 14 YEARS
21AA The patient must be 14 years of age or older to qualify for a Workers' Compensation Board claim.

21AB WORKERS' COMPENSATION BOARD CLAIM SUBMISSIONS
21AB Payment was refused as effective June 1, 2000 Workers' Compensation Board claims are to be submitted directly to the Workers' Compensation Board.

21B WORKERS' COMPENSATION BOARD (OUT OF PROVINCE)
21B This claim is the responsibility of another Province's Workers' Compensation Board. Please submit the claim directly to the appropriate Workers' Compensation Board.

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

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

23A PRIOR APPROVAL
23A Payment was refused as:
23A (a) this service requires prior approval from the patient's Provincial Medical Plan and/or
23A (b) prior approval was not received for this date of service.

24A PODIATRY SERVICES ONLY PAYABLE IN OFFICE FACILITY
24A This service is only payable when performed in an office.

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

25A MEDICAL RECIPROCAL - INCORRECT CLAIM
25A Payment was refused as you have submitted a Medical Reciprocal claim for services provided to an Alberta patient.

28 OPTED OUT PRACTITIONER
28 This service was provided by a Practitioner who has opted out of the Alberta Health Care Insurance Plan and there is no indication that this was an emergency service.
28 INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED

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

30A PROVINCE CODE
This claim was refused as the Province Code on the Person Data Segment is invalid, incomplete or blank.

30AA CITY NAME
This claim was refused as the City Name on the Person Data Segment is invalid, incomplete or blank.

30AB COUNTRY CODE
This claim was refused as the Country Code on the Person Data Segment is invalid, incomplete or blank.

30AC POSTAL CODE
This claim was refused as the Postal Code on the Person Data Segment is invalid.

30B DATE OF BIRTH
This claim was refused as the Date of Birth on the Person Data Segment is:
(a) blank
(b) invalid
(c) incomplete
(d) after the date of service

30BA GENDER
This claim was refused as the Gender on the Person Data Segment is invalid or blank.

30E SURNAME
This claim was refused as the Surname on the Person Data Segment is invalid or blank.

30EA FIRST NAME
This claim was refused as the First Name on the Person Data Segment is invalid or blank.

30EB MIDDLE NAME
This claim was refused as the Middle Name on the Person Data Segment is invalid or blank.

30F PERSON TYPE
This claim was refused as the Person Type on the Person Data Segment is invalid or blank.

30G GUARDIAN/PARENT PERSONAL HEALTH NUMBER
This claim was refused as the Guardian/Parent Personal Health Number on the Person Data Segment is invalid or blank.

30H GUARDIAN/PARENT HEALTH PLAN NUMBER
30H This claim was refused as the Guardian/Parent Health Plan Number on the
30H Person Data Segment is invalid or blank.

31 INCOMPLETE PERSON DATA
31 This claim has been refused as the Person Data Segment is:
31 (a) required
31 (b) incomplete for the Person Type submitted
31 (c) required as we have no record of the Personal Health Number which was
31 submitted.

31A PERSON DATA SEGMENT CONFLICT
31A The Out of Province registration number and the Person Data Segment do not
31A match the service recipient information in our files.
31A Confirm the patient's Out of Province health care card registration number,
31A home province/recovery code, and personal data information with the patient
31A or the patient's home provincial health plan. If applicable, submit a new
31A claim with supporting text indicating that the physician has verified the
31A patient's personal information.

34AA CLAIM CURRENT YEAR SEGMENT
34AA The current year indicated within the claim number is not numeric or not the
34AA current year.

34AB CLAIM SEQUENCE NUMBER
34AB The claim sequence number indicated within the claim number is not numeric.

34AC CLAIM CHECK DIGIT
34AC The check digit number indicated within the claim number is invalid.

34AD ACTION CODE
34AD The action code is inconsistent with other information segments within this
34AD transaction.

34B EMSAF INDICATOR
34B The EMSAF (Extraordinary Medical Services Assessment Fund) indicator is
34B invalid.

34C CLAIM RECORD TYPE
34C The record type is invalid. To process the claim the record type must be:
34C (a) number 2 in the (batch header) data field
34C (b) number 3 in the (claim detailed record) field
34C (c) number 4 in the (batch trailer) data field
34C Refer to the Electronic Claims Submissions Specifications Handbook.

34DA CLAIM TRANSACTION TYPE
34DA The transaction type is not CIPI.
34DA Refer to the Electronic Claims Submissions Specifications Handbook.

34DB CLAIM SEGMENT TYPE
34DB The segment type must be:
34DB (a) CIBI - claim regular or
34DB (b) CPDI - person data segment or
34DB (c) CSTI - text segment or
34DB (d) CTXI - text cross reference segment or
34DB  (e) in proper order
34DB  Refer to the Electronic Claims Submissions Specifications Handbook.

34DC  SEGMENT SEQUENCE NUMBER
34DC  The segment sequence number is not incremental.
34DC  Refer to the Electronic Claims Submissions Specifications Handbook.

34DD  CST1 SEGMENT REQUIRED
34DD  At least one CST1 segment must be submitted with an "R" (Reassess Action Code) transaction.
34DD  Refer to the Electronic Claims Submissions Specifications Handbook.

34DE  MAXIMUM CST1 SEGMENT
34DE  The maximum number of CST1 segments (500) was exceeded.

34DF  CIB1 SEGMENT REQUIRED
34DF  Only provide a "CIB1" Base Claim Segment when submitting a "D" (Delete Action Code) transaction.

34DG  CPD1 SEGMENT NOT ALLOWED
34DG  A "CPD1" Person Data Segment cannot be provided when submitting an "R" (Reassess Action Code) transaction.

34DH  MAXIMUM CPD1 SEGMENT
34DH  A transaction cannot have more than one "CPD1" Person Data Segment for any one person data type.

34EA  CLAIM TEXT SEGMENT
34EA  The text information you supplied is not in alpha numeric format.

34EB  CLAIM SOURCE CODE
34EB  The claim source code is invalid.
34EB  Refer to the Electronic Claims Submissions Specifications Handbook.

34EC  SUPPORTING TEXT CROSS REFERENCE
34EC  The supporting text cross reference segment claim(s) number has failed the claim check algorithm.
34EC  Refer to the Electronic Claims Submissions Specifications Handbook.

34ED  CTX1 AND CST1 SEGMENT
34ED  The transaction being cross referenced and referred by a "CTX1" Text Cross Reference Segment must have a "CST1" Text Segment.

34F  CHART NUMBER
34F  The chart number information was not in alpha numeric characters. Only ASCII print characters are valid for this field.

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

35A INTERCEPT
35A The Intercept code on the claim is invalid.

35B RECOVERY CODE
35B The Recovery Code on the claim is invalid or not allowed for this Business
35B Arrangement.

35C REASSESS REASON CODE
35C The Reassess Reason Code on the claim is invalid or blank.

35D CLAIM TYPE
35D The Claim Type on the claim is invalid or blank.

35E CONFIDENTIAL INDICATOR CODE
35E The Confidential Indicator Code on the claim is invalid.

35F CLAIM NUMBER
35F The Claim Number on the claim is invalid or blank.

35FA SUBMISSION OF A CLAIM NUMBER
35FA The Claim Number submitted was previously used on a:
35FA (a) refused claim or
35FA (b) claim which is being held or
35FA (c) paid service event or claim applied at a zero amount

35FB UNABLE TO PROCESS UPDATED TRANSACTION
35FB The transaction to update a previously submitted claim cannot be processed
35FB as:
35FB (a) the original add transaction cannot be located or
35FB (b) the result of your original claim must be known or
35FB (c) the original claim was previously deleted

35FC UNABLE TO PROCESS ADD TRANSACTION
35FC This claim number submitted was previously used and the add "A" transaction
35FC cannot be processed. If applicable, submit the original claim number with
35FC the appropriate action code of "R" reassess, "C" change or "D" delete.

35G GOOD FAITH INDICATOR
35G The Good Faith Indicator on the claim is invalid.

35H SUPPORTING DOCUMENTATION INDICATOR
35H The Supporting Documentation Indicator on the claim is invalid.

35J TEXT INDICATOR
35J The Text Indicator on the claim is invalid.

35K PAY TO CODE
35K The Pay to Code on the claim is invalid or cannot be changed.

35KA PAY TO CODE/PAY TO ULI CONFLICT
35KA There is a conflict between the information shown in the Pay to Code and
35KA the Pay to ULI fields. When the Pay to Code is "OTHR" (other) the Pay to
35KA ULI cannot be the:
35KA (a) Service Provider or
35KA (b) BA Payee or
35KA (c) Patient or
35KA (d) AH Registration contract holder responsible for the patient.

35L PAY TO ULI
35L The Pay to ULI on the claim is invalid or blank.

35M NEWBORN CODE
35M The Newborn Code is invalid or not required when the patient's Personal
35M Health Number is already provided on the claim.

36 LOCUM BUSINESS ARRANGEMENT
36 The Locum Business Arrangement number on the claim is invalid or not
36 required.

36A LOCUM/BUSINESS ARRANGEMENT NUMBERS
36A The Locum Business Arrangement and the Business Arrangement fields were not
36A completed properly. Please refer to the "Physician's Resource Guide" and
36A submit a new claim.

37 BUSINESS ARRANGEMENT
37 The Business Arrangement number on the claim:
37 (a) is invalid or blank or
37 (b) is restricted to performing specific services or
37 (c) is restricted to performing services at a specific facility or
37 (d) is not registered with the Submitter of the transaction or
37 (e) does not have a relationship with the Practitioner Identifier (PRAC ID)
37 submitted or
37 (f) is restricted to patients from a specific area.

37A Practitioner Identifier (PRAC ID)
37A The Service Provider ID (PRAC ID) field is blank, invalid or not effective
37A for the date of service submitted.

37B SKILL CODE
37B The Skill Code on the claim is invalid or blank.

39 DATE OF SERVICE
39 The Date of Service for the claim is:
39 (a) invalid or blank or
39 (b) more than 1 year from Date of Birth (Newborn) or
39 (c) in conflict with the explicit modifier indicated

39A DATE OF SERVICE CONFLICT
39A The Date of Service for the claim and the Supporting Documentation do not
39A agree.

39B HEALTH SERVICE CODE
39B Payment has been refused as the Health Service Code on the claim is:
39B (a) blank or invalid or
39B (b) not listed in the applicable Alberta Health Care Insurance Plan

C:\Documents and Settings\Raj\My Documents\AHC\ExplanationCodes.doc
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39B Schedule of Benefits

39BA GENDER RESTRICTION
39BA The Health Service Code and/or diagnosis submitted does not agree with the
39BA gender of the patient.

39BB AGE RESTRICTION
39BB The patient does not qualify for this service due to the age restriction.

39BC HEALTH SERVICE CODE NOT APPROPRIATE FOR DIAGNOSIS
39BC The type of service provided does not agree with the diagnosis.

39BD DATE OF SERVICE/HEALTH SERVICE CODE DATE CONFLICT
39BD The Health Service Code is not effective on this date of service.

39BE CONCEPTUAL AGE
39BE Payment for the additional benefit has been refused as the patient's
39BE conceptual age is greater than 26 weeks.

39C NUMBER OF CALLS
39C This claim was refused as:
39C (a) the number of calls is invalid or blank or
39C (b) the number of calls on the claim is more than the number allowed for
39C this service.
39C Submit applicable claims with text information.

39D LOCATION OF SERVICE
39D The Location of Service on the claim is not appropriate for the Health
39D Service Code indicated.

39DA FACILITY NUMBER
39DA The Facility Number on the claim is invalid or blank.

39DB FUNCTIONAL CENTER CODE
39DB The Functional Center Code on the claim:
39DB (a) is blank or invalid
39DB (b) does not exist for the facility submitted
39DB (c) is restricted from performing the service submitted

39DC ORIGINATING FACILITY NUMBER
39DC The Collection Facility Number on the claim is invalid or blank.

39DD ORIGINATING LOCATION
39DD The originating location on the claim is:
39DD (a) invalid or blank
39DD (b) not required when the Originating Facility Number is completed.

39DE ORIGINATING FACILITY NUMBER/LOCATION FOR PATHOLOGY SERVICES
39DE The Originating Facility Number or the Originating Location Field is
39DE required for Pathology Services (E Codes).

39EB DIAGNOSTIC CODE
39EB The Diagnostic Code on the claim is blank or invalid.
39EC HEALTH SERVICE CODE AND DIAGNOSTIC CODE CONFLICT
39EC The claim was refused as the health service code and the diagnostic code on
39EC the claim are in conflict.

39F USE CLAIMED AMOUNT INDICATOR
39F The "Use Claimed Amount Indicator" on the claim is invalid.

39FA AMOUNT CLAIMED/USE CLAIMED AMOUNT INDICATOR
39FA Your claim was refused as:
39FA (a) the amount claimed is blank. Claims for unlisted procedures (health
39FA service codes in the 99.09 series) require a claimed amount and a "Y"
39FA in the claimed amount indicator field or
39FA (b) the amount claimed is blank or invalid and the claimed amount indicator
39FA is "Y" or
39FA (c) the amount claimed is completed, but the claimed amount indicator is
39FA blank or invalid.

39G MODIFIER CODE
39G The Modifier Code field:
39G (a) is required with the service submitted
39G (b) is invalid
39G (c) can only have one modifier of the same type
39G (d) can not have this combination of modifiers.
39G (e) must have a valid two digit numeric suffix when modifier type is SURT

39H TELEHEALTH SERVICES
39H This claim was refused as the health service code and the modifier code are
39H in conflict for the following reasons:
39H (a) "STFO" (store and forward modifier) applies only to teledermatology or
39H (b) "TELES" (telehealth modifier) applies only to consultations and non-
39H referred visits 03.01C, 03.03A and 03.04A.

41 DOCUMENTATION INCOMPLETE/NOT RECEIVED
41 The Supporting Documentation for this claim was incomplete or not received.

41B TIME/SITES - E.H.B.
41B Submit a new claim indicating the number of units, quadrants or sextants.

42 HOSPITAL ADMISSION/ORIGINATING ENCOUNTER DATE
42 The Hospital Admission/Original Date on the claim is invalid or blank.

43 OUT OF PROVINCE HEALTH PLAN NUMBER
43 The Out of Province Health Plan number on the claim is invalid or blank.

45 INVALID REFERRING PRACTITIONER IDENTIFIER (PRAC ID)
45 The Referring Practitioner's Identifier (PRAC ID) on the claim is:
45 (a) blank or invalid or
45 (b) not an intraspecialty or
45 (c) from a practitioner without the appropriate discipline or skill

45A OUT OF PROVINCE REFERRAL INDICATOR
45A The Out of Province Referral Indicator on the claim is invalid.

45AA REFERRAL PRACTITIONER IDENTIFIER (PRAC ID) INVALID UNABLE TO RESOLVE
45AA Your claim has been refused as the Referral Practitioner Identifier
45AA (PRAC ID) is invalid. Contact the referring practitioner for the correct
45AA Practitioner Identifier (PRAC ID).

45B ENCOUNTER NUMBER
45B The Encounter number on the claim is invalid.

47 SERVICE RECIPIENT PERSONAL HEALTH NUMBER (PHN)
47 This claim was refused as the Service Recipient PHN cannot be changed.
47 Delete the original claim and submit a new claim with the correct Service
47 Recipient PHN.

48 PRACTITIONER IDENTIFIER (PRAC ID)
48 This claim was refused as the Practitioner Identifier (PRAC ID) cannot be
48 changed. Delete the original claim and submit a new claim with the correct
48 Practitioner Identifier (PRAC ID)

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

50 TWO PHYSICIANS - UNRELATED ABDOMINAL SURGICAL PROCEDURES
50 Payment was reduced to 75% of the fee as the full benefit for the major
50 procedure was paid to the physician most responsible for the patient's care.

50A PROCEDURES INCLUDED IN THE MAJOR PROCEDURAL BENEFIT
50A Payment was refused as this service is included in the fee paid for the
50A major procedure.

50AA DIAGNOSTIC PROCEDURES RELATING TO SURGERY
50AA Payment was refused as the diagnostic procedure is included in the benefit
50AA paid for the surgical procedure when performed under the same anaesthetic.

50AB SECOND OR SUBSEQUENT PROCEDURE
50AB Payment for the procedural component was reduced to 50% as this service was
50AB performed as a second or subsequent procedure through the same incision.
50AB Please refer to the notes following the health service code.

50B REPEAT CLOSED REDUCTION - SAME PRACTITIONER
50B Payment was refused as a repeat closed reduction performed by the same
50B practitioner is not payable.

50BA REPEAT CLOSED REDUCTION - DIFFERENT PRACTITIONER
50BA Payment was reduced to 50% as a different practitioner has performed a
50BA repeat closed reduction for the same fracture or dislocation.

50BB CLOSED - OPEN REDUCTION - DIFFERENT PRACTITIONER
50BB Payment was reduced to 50% as a different practitioner has performed an
50BB open reduction for the same fracture.

50BC CLOSED - OPEN REDUCTION - SAME PRACTITIONER
50BC Payment was refused as a closed reduction is not payable when the same
50BC practitioner performs an open reduction for the same fracture under the same anaesthetic.

51 PRE- AND/OR POST-OPERATIVE CARE - TWO PRACTITIONERS
51 Payment was reduced or refused as another Practitioner was paid for pre-and/or post-operative care.

51A UNILATERAL - BILATERAL PROCEDURES
51A Payment was reduced as the fee does not increase when a bilateral procedure is performed.

51G SURGICAL ASSISTS
51G Payment was refused according to General 13, for one of the following reasons:
51G (a) a surgical assist fee is not payable for the procedure performed
51G (b) a surgical procedure was not claimed for this date of service or
51G (c) documentation was not submitted to support a claim involving unusual circumstances.

52 PROCEDURES - RESUBMISSION
52 Payment was refused as this service cannot be paid when an associated procedure was claimed within 90 days.
52 See the NOTE in the Schedule of Medical Benefits following the health service code claimed.

52A LACERATIONS
52A Payment was made according to the explanation following Health Service Code 98.22B.

52B SAME PHYSICIAN - TWO FUNCTIONS
52B Payment was refused as only one benefit can be paid when both surgical and anaesthetic services are performed by the same physician.

53A CHORIONIC VILLUS SAMPLING
53A Payment was refused as benefits for Chorionic Villus Sampling are only payable when the service is provided in a hospital.

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

54A POST-NATAL MAXIMUM
54A Payment was refused as only one routine post-natal visit, per physician, is payable.
54B PRE-NATAL CARE
54B Payment was refused as:
54B (a) only one 03.04B may be claimed per pregnancy per physician.
54B (b) Health Service Code 03.04B may not be charged within 91 days of a major visit item.
54B (c) a 03.03B benefit may only be claimed for the pre-natal visits and may not be claimed for date of service following a delivery.

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

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

B VARICOSE VEINS INJECTIONS
Payment was refused as the maximum for the Benefit Year (July 1 to June 30)
was paid.
The Schedule of Medical Benefits allows one initial 51.92A, three 51.92B's,
six repeat 51.92A's and up to eighteen 51.92B services for each patient per
Benefit Year.

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

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

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

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

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

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

C MULTIPLE BENIGN SKIN LESIONS
58C Payment was reduced or refused as only a single anaesthetic benefit is payable when surgical treatment of multiple benign skin lesions are performed under 45 minutes of anaesthetic.

58D RESUSCITATION
58D Payment was refused as Health Service Code 13.99E can only be paid when the physician is specially called for resuscitation. Submit a new claim using the appropriate Health Service Code 13.99J or 13.99F.

58E RELATED ANAESTHETIC CODE
58E Payment was made according to the information submitted on the Surgeon's claim.

58F ADDITIONAL AGE BENEFIT
58F Payment was reduced according to General Rule 12.7. Only one additional anaesthetic benefit per patient encounter is payable regardless of the number of services provided.

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

60A CONSULTATION - INCLUSIVE BENEFIT
60A Payment was refused as a consultation benefit is included in the payment for the procedure.

60AA CONSULTATION
60AA Payment was reduced to the rate payable for a non-referred visit item as: (a) the service does not meet the requirements of a consultation or (b) the referral was not from a physician or (c) the referral was from a family member.

60B DENTAL CONSULTATION
60B Payment was refused as a dental consultation is only payable when it is requested by the patient's Physician, Dental Surgeon, or Oral and Maxillofacial Surgeon and it concerns a procedure payable under the Schedule of Oral and Maxillofacial Surgery Benefits.

60C HOSPITAL ADMISSION
60C Payment was refused as an admission is not payable when the patient was seen by the same Practitioner on the same day for the same or related diagnosis.

60E EMERGENCY DEPARTMENT/AACC/UCC VISITS
60E Payment was refused as: (a) another physician has claimed for the same service. Submit a new claim with a DSCH modifier according to General Rule 5.1 or (b) Health Service Code 03.05F cannot be claimed by the same physician who provided the initial assessment prior to determining the disposition status of the patient.

60EA CRITICAL CARE - EMERGENCY DEPARTMENT/AACC/UCC VISIT
60EA Payment was refused as the information/diagnostic code provided does not support payment under this Health Service Code. Submit a new claim with the appropriate emergency department/AACC/UCC visit.
60EB SERVICES UNSCHEDULED
60EB Payment was refused as the maximum benefit for unscheduled services was
60EB reached.

60EC SPECIAL CALLBACKS TO AACC/UCC HOSPITAL EMERGENCY OUT-PATIENT DEPARTMENT
60EC Payment was refused according to General Rule 5.2 in the Schedule of Medical
60EC Benefits or General Rule 17 in the Schedule of Oral and Maxillofacial
60EC Surgery Benefits.

60ED MAXIMUMS FOR SPECIAL CALLBACKS AND SURCHARGES
60ED Your claim was reduced in accordance with one of the Governing Rules 15.11.1
60ED through 15.11.5 in the Schedule of Medical Benefits.

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

61A GENERALIZED DIAGNOSTIC CODES
61A Payment was refused as this service is included in the benefit paid for the
61A related surgical procedure.

61B REMOVAL OF SUTURES
61B Payment was refused as the fee for removal of sutures is included in the
61B surgical benefit according to General Rule 6.3 in the Schedule of Medical
61B Benefits or General Rule 6.1 in the Schedule of Oral and Maxillofacial
61B Surgery Benefits.

61C NURSING HOME AND SENIOR CITIZENS HOME
61C Payment was refused as the service was not provided in a "home" location
61C as specified in Governing Rule 1.6.

61CA AUXILIARY HOSPITAL VISITS
61CA Payment was reduced to a lesser benefit as the service provided was a
61CA routine visit for custodial care.

61CB AUXILIARY HOSPITAL/NURSING HOME VISIT/MANAGEMENT OF DIALYSIS PATIENTS
61CB Payment was refused as a visit for a prior date of service during the same
61CB calendar week was paid.

61E CONCURRENT CARE
61E Payment was reduced or refused as services for concurrent care require
61E supporting information according to General Rule 4.8 in the Schedule of
61E Medical Benefits or General Rule 13 in the Schedule of Oral and
61E Maxillofacial Surgery Benefits.

61EA CONTINUING CARE
61EA Payment was reduced or refused according to General Rule 4.10 in the
61EA Schedule of Medical Benefits or General Rule 14 in the Schedule of Oral and
61EA Maxillofacial Surgery Benefits.

61F CONFLICTING HOSPITAL DATES
61F Payment was reduced or refused as a benefit for some or all of the hospital
61F  dates of service was previously paid.

61G  POST-PARTUM OFFICE VISITS
61G  Payment was refused as this service is not payable when provided to a
61G  healthy newborn during the post-partum period.

61H  INCLUSIVE - SURGICAL BENEFIT - PRE/POST-OPERATIVE CARE
61H  Payment was refused as the service(s) for pre/post operative care is
61H  included in the surgical benefit.

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

63  CLAIM IN PROCESS
63  Your claim is being held as:
63  (a)  it requires manual assessment or
63  (b)  the supporting information must be reviewed
63  DO NOT SUBMIT A NEW CLAIM as notification of payment or refusal will appear
63  on a future Statement of Assessment.

63A  SCHEDULE OF BENEFITS
63A  Payment for your claim was reduced or refused in accordance with the
63A  Governing Rules and/or the Health Service Code Notes in the Schedule of
63A  Medical Benefits. To view the Schedule of Medical Benefits, please go to
63A  our website at:  www.health.gov.ab.ca.

63AA  UNSCHEDULED SERVICES & DESIGNATED HOLIDAYS
63AA  Payment was reduced or refused according to General Rules 1.2 and 15 in the
63AA  Schedule of Medical Benefits or General Rules 1.10 and 17 in the Schedule of
63AA  Oral and Maxillofacial Surgery Benefits.

63B  MAXIMUM NUMBER OF CALLS
63B  Payment was reduced as the maximum number of calls for the Health Service
63B  Code was reached.

63C  INCLUSIVE HEALTH SERVICE CODE
63C  Payment was refused as there is an inclusive Health Service Code in the
63C  Schedule of Benefits for these services.

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

64AA  UNANSWERED CORRESPONDENCE/TELEPHONE RESPONSE
64AA  Payment was refused as our requests for additional information were not
64AA  answered.

64AB  RELATIONSHIP
64AB  Payment was refused as the relationship of the relative being interviewed
64AB  was not provided.
64B PROCEDURES REQUIRING APPROPRIATE FACILITY TYPE
64B Payment was refused as the service claimed is only payable in a hospital or surgical suite.

64C INFORMATION PROVIDED
64C The information provided has been reviewed and payment was:
64C (a) reduced or refused or
64C (b) unchanged or
64C (c) altered and future claims of this nature should be submitted under the applicable health service code. Unlisted procedures are to be claimed only for new procedures not listed in the schedule.

64D ANAESTHETIC AND SURGERY DISCREPANCY
64D Payment was refused as there is a discrepancy between the Health Service Code shown on the anaesthetic and the surgery claim.

64E DATE CONFLICT
64E Payment was refused as the date of service does not agree with the anaesthetist's, surgical assistant's or surgeon's claim.

65 NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL, AACC OR UCC
65 Benefits for non-invasive diagnostic procedures performed for a hospital inpatient, registered outpatient, AACC or UCC patient are not payable under the Schedule. Payment for these services is the responsibility of the hospital/Regional Health Authority. This applies to both the technical and professional components.

65A BLOOD SPECIMEN
65A This claim was refused as payment cannot be made:
65A (a) for both obtaining a blood specimen and a lab test requiring blood or
65A (b) for services performed by non-laboratory facilities

65AA MISCELLANEOUS LABORATORY PROCEDURES
65AA Payment was refused according to the following:
65AA (a) Claims submitted for E1 and/or combination of E2, E3, E4, E5 and E7 for the same date of service are not payable in excess of the listed benefit for E1. Or
65AA (b) The greater benefit is paid when claims are submitted for Health Service Code E1 and E41 or E400 for the same date of service. Or
65AA (c) The greater benefit is paid when claims are submitted for E234 and E235 for the same date of service. Or
65AA (d) A maximum of either one E553 and one E554 or two E553's or two E554's are paid within a 14 day period.

65C DIAGNOSTIC ULTRASOUND
65C Payment was refused as when claims are submitted for the same date of service for combinations of:
65C (a) X222 - X233 inclusive
65C (b) X234 - X244 inclusive
65C only the greater benefit is paid. Benefits are payable for both the greater of (a) and the greater of (b) when provided on the same date of service. Or
65C (c) X258 is not payable in addition to X234, X235, X239A, X240, X241, X242, X243.
65D ALLERGY INVESTIGATIONS
65D Payment was reduced or refused as the maximum benefit payable for the 365
day period was reached.

65E DETENTION TIME
65E Payment was refused as supporting information must provide a breakdown of
the procedures performed during the time of continuous attendance spent with
the patient and the time of attendance during the ambulance trip, if
applicable.

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

66A VENTILATORY SUPPORT
66A Payment was reduced or refused for one of the following reasons:
66A (a) Ventilatory support may be claimed only once per 24 hour period,
regardless of the number of physicians providing care
66A (b) Ventilatory support is not paid for the same date of service by the
same physician who has provided either an anaesthetic or surgical
procedure
66A (c) Ventilatory support is not paid unless provided in approved level 2 and
3 intensive care units
66A (d) A surcharge is not payable with benefit code 13.62A, but an after hour
callback or surcharge is payable under benefit code 03.05P, 03.05R,
03.05Q or 03.05N
66A (e) In accordance with Governing Rule 5.4.

67 MULTIPLE CHARGES/SAME ENCOUNTER
67 Payment was refused as claims for multiple services provided in the same
encounter require supporting information.

67A PREVIOUS PAYMENT
67A Payment for this service was refused as:
67A (a) the claim was previously paid or
67A (b) the claim was applied at "0" on a previous Statement of Assessment.
67A Requests for a reassessment of applied at "0" claims must be submitted
with the original claim number and the appropriate action code of "C"
(Change), "D" (Delete) or "R" (Reassess).
67A (c) the claim was previously paid under a different health service code for
the same service in either the Schedule of Podiatry Benefits or the
Schedule of Podiatric Surgery Benefits.
67A Exception: Hospital Reciprocal claims must be resubmitted as described in
the Alberta Health and Wellness Hospital Reciprocal Claim Submission Guide.

67AA PAYMENT TO CONTRACT HOLDER/PATIENT
67AA Payment was refused as the benefit for this service was paid to the patient/
contract holder.

67AB PREVIOUS PAYMENT - DIFFERENT HEALTH SERVICE CODE
67AB Payment was refused as a benefit was paid under a different Health Service Code.

67AC PREVIOUS PAYMENT
67AC Payment was refused as this benefit was paid to another practitioner.

67AD DUPLICATE - DIFFERENT SERVICE DATE
67AD Payment was refused as this claim appears to be a duplicate of a paid benefit, although the dates of service do not agree. If this is not a duplicate, submit a new claim with supporting information.

67AE PREVIOUS PAYMENT WARD RATE/ICU RATE
67AE Payment for this service was refused as:
67AE a) the ward rate was previously paid or
67AE b) the ICU rate was previously paid.

67B LOCATION OF SERVICE CONFLICT
67B Payment was refused as claims were paid for services that the patient received on this date at a different location/hospital. Verify the dates of service and resubmit applicable claims with additional details.

67D MEDICAL STAFF - ASSESSMENT
67D This claim has been assessed according to the advice received from our medical staff. A review of this assessment by the Assessment Advisory Committee can be requested by submitting a new claim with relevant information.

67DA RELATED ASSESSMENT
67DA Accounts of a similar nature have been reviewed by the Assessment Advisory Committee and this claim has been assessed according to their recommendations.

67DB FINAL ASSESSMENT
67DB This claim has been paid, reduced or refused as recommended by the Assessment Advisory Committee.

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

69 ALTERNATIVE PAYMENT PLAN ADDITIONAL FEE FOR SERVICE PAYMENTS
69 An additional fee for service payment was paid due to additional supporting documentation for special circumstances.

70 PRE/POST-OPERATIVE CARE
70 This claim was assessed in accordance with General Rule 16.1 in the Schedule of Oral and Maxillofacial Surgery Benefits or General Rule 6.2 in the Schedule of Dental Extended Health Benefits.

70A TWO DENTAL PROCEDURES - TWO INCISIONS
70A Payment was reduced to 75% of the listed benefit as the major surgical
70A  procedure was paid at the full rate.

70AA  TWO DENTAL PROCEDURES - ONE INCISION
70AA  Services for lesser value procedures are reduced to 75% of the listed
70AA  benefit, as the major surgical procedure was paid at the full rate.

70D  INELIGIBLE DENTAL SERVICES
70D  Payment has been refused as:
70D  (a) tissue conditioning is only payable in conjunction with a denture
70D  or reline within five years. There is no reline or denture claimed
70D  for this period
70D  (b) tissue conditioning is not payable within three months of a partial
70D  or complete denture insertion as this is included with the benefit
70D  for the denture
70D  (c) only two tissue conditioning benefits are payable for a denture
70D  or reline within five years. You have reached the maximum allowed
70D  for a tissue conditioning benefit.

70E  TOOTH IDENTIFICATION
70E  Payment has been refused as:
70E  (a) identification of tooth numbers and surfaces are required as
70E  applicable
70E  (b) the tooth surface field for this procedure should be blank
70E  (c) the tooth surface(s) indicated is/are NOT valid for the tooth code
70E  submitted
70E  (d) the tooth number indicated is not valid for this procedure.

70EA  DENTAL EXTRACTION
70EA  Payment was refused as our records show this tooth was previously extracted.

70EB  TOOTH SURFACE/TOOTH CODE
70EB  Payment was refused as the tooth surface or tooth code is invalid.

70F  DENTURES/REBASE/RESET
70F  Payment was refused for one of the following reasons:
70F  (a) a benefit was paid for a complete denture within the last 5 years. or
70F  (b) a benefit was paid for a partial denture within the last 5 years.

70G  RELINE OR REBASE
70G  Payment was refused as benefits were paid for a reline in the past 2 years.

70J  INCLUSION WITHIN THE COMPOSITE BENEFIT
70J  Payment was refused as the service is included in the benefit for the
70J  major procedure.

70K  INELIGIBLE DENTAL MECHANICS SERVICES
70K  Payment was reduced or refused for the following reasons:
70K  a) Only one oral examination per day is payable when a corresponding new
70K  denture or reline benefit is provided on or after January 1,2001 and paid
70K  by the Alberta Health and Wellness Extended Health Benefits program or
70K  b) only one oral examination is payable for each new denture or reline
70K  service provided or
70K  c) an oral examination occurred within 90 days of the denture/reline
70K  service. The examination is included in the benefit for the denture/
reline or

d) an oral examination is not payable if performed more than 365 days after a denture or reline benefit was provided.

DENTAL PROCEDURES
Payment was refused as when multiple services are claimed for the same date of service, the following rules apply:
(a) only the greater benefit of a minor procedure, consultation or any visit is payable when the services and diagnosis are related or
(b) only the greater benefit of a minor (M or M+) procedure or a hospital visit is payable, regardless of the diagnosis or
(c) only the greater benefit of a minor (M+) procedure or a visit is payable when performed in a location other than an Oral and Maxillofacial Surgeon's or Dentist's office, or surgical suite, regardless of the diagnosis or
(d) an office visit benefit is not payable with a minor (M+) procedure and a consultation, regardless of whether the services are performed at different encounters.

AHC AND WCB CLAIM FOR THE SAME VISIT
Payment was refused as a benefit was paid for a Workers' Compensation Board claim.

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

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

ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6
Payment was refused as non-residents, Allied Health Providers and subscriber claims do not qualify for additional benefits under GR 2.6.

ADDITIONAL COMPENSATION COMMITTEE/ ASSESSMENT ADVISORY SUBCOMMITTEE ASSESSMENT
This claim was paid, reduced or refused as recommended by the Additional Compensation Committee or Assessment Advisory Subcommittee.

INCORRECT ADDITIONAL COMPENSATION CLAIM SUBMISSION
Payment was refused as the claim for additional compensation was submitted incorrectly. Refer to the Physician's Resource Guide and resubmit appropriately.

NO PAYMENT BY ALBERTA HEALTH INSURANCE PLAN
Payment of the additional compensation portion of the claim was refused as there is no record of an Alberta Health Care Insurance Plan payment for this service.

REQUEST FOR ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6
Payment was refused as supporting documentation is required for the additional compensation portion of the claim.
73BD  NON-INSURED SERVICE
73BD  Payment was refused as this service is not insured by Alberta Health Care.

73BE  CHANGE OF PAYMENT RESPONSIBILITY
73BE  This additional compensation claim was paid as an Alberta Health Care
73BE  Insurance Plan benefit.

80  RESIDENCY/GOOD FAITH
80  Payment was refused as Good Faith Claims must be submitted within 30 days
80  of the date of service.

80B  EYE EXAMINATIONS
80B  Payment was refused as this is the second claim for this type of eye exam
80B  provided to this patient within the Benefit Period. (July 1 to June 30.)

80BA  OPTOMETRIC SERVICES
80BA  Payment was refused as either a Complete Vision Examination, a Partial
80BA  Vision Examination or Single Diagnostic Procedure was paid for the same date
80BA  of service or the maximum benefit allowed was reached.

80BB  OPTOMETRIC SERVICES DEFAULT PRICE ADJUSTMENTS
80BB  This is a repayment of benefits that were reduced by implementation of the

80BD  FOLLOW-UP VISIT (B901) - TEXT REQUIRED
80BD  Payment for the B901 was refused as the patient received the corresponding
80BD  B900 within 90 days and no explanatory text was provided on the claim.
80BD  Subject to the Optometric Benefits Regulations section 12(2), a claim for a
80BD  B901 performed within 90 days of a B900, where the diagnostic code falls
80BD  within Optometric Benefits Regulation section 12(1), must be accompanied
80BD  with explanatory text unless the resident's eye care is subject to a
80BD  co-management arrangement.

80BE  MAXIMUM BENEFIT REACHED
80BE  Payment was refused as the patient has received the maximum benefits
80BE  payable for this condition/episode subject to the rules set out in the
80BE  Optometric Benefits Regulation sections 12(1), 12(3) and 12(4).

80BF  PREVIOUS PAYMENT, SAME DATE OF SERVICE
80BF  Payment was refused as:
80BF  a) Benefit was paid under a different health service code
80BF  b) Benefit was paid to another practitioner
80BF  c) Benefit was previously paid

80BH  COMPUTER ASSISTED VISUAL FIELDS (B905) - TEXT REQUIRED
80BH  Payment was refused as no explanatory text was provided on the claim.
80BH  Subject to the Optometric Benefits Regulation section 13(2), a claim for a
80BH  B905 must be accompanied with explanatory text unless the diagnostic code
80BH  stipulated on the claim is ICD-9 code 365- Glaucoma; ICD-9 code 361- Retina
80BH  Detachments & Defects; or ICD-9 code 377 - Disorders of the Optic Nerve &
80BH  Visual Pathways.

80C  PODIATRIC/CHIROPRACTIC/DENTAL LIMITS
80C  This claim has been reduced or refused as:
80C (a) the yearly limit for Podiatric benefits has been reached however payment may be reviewed at a later date if we receive changes to other related claims for this patient.
80C (b) the yearly limit for Chiropractic benefits has been reached.
80C (c) the calendar year limit for the following dental service(s) has been reached:
80C - benefit for only two examinations of any type may be paid in
80C - benefit for only two films may be paid in a calendar year
80C - benefit for panoramic x-rays may be paid once every five
80C - benefit for no more than two units of time (30 minutes) for

80CA LIMIT ON DAILY VISIT
80CA This claim has been reduced or refused as this patient has reached the limit allowed for this date of service.

80D EYEGLASSES/LENSES/FRAME
80D Payment has been reduced or refused as this patient has received:
80D (a) eyeglasses within the last 3 years
80D (b) lenses/lens within the last 3 years

80E SECOND CHIROPRACTIC X-RAY
80E Payment was refused as this is the second x-ray for this benefit year.
80E (July 1 to June 30.)

80F 12 MONTH LIMIT
80F Payment has been reduced or refused as the patient has received this benefit within 12 months.

80G OUTDATED CLAIMS
80G Payment was refused as the time limit for submission has expired.

80H CONTRACT LIMITS
80H Payment was reduced or refused as the Contract Limit was reached.

80J PRACTITIONER/BUSINESS ARRANGEMENT LIMITS
80J Payment was reduced or refused as the limit was reached for the Service Provider or the Business Arrangement.

80K RECIPIENT LIMIT HAS BEEN REACHED FOR APP CONTRACT
80K Payment was refused or reduced as the recipient has reached capitation rate.

80L ALTERNATIVE PAYMENT PLAN FEE FOR SERVICE
80L Payment was reduced as the capitation maximum was paid for the month of service.

90 PAYMENT REDUCTION
90 This is an adjustment of a previously assessed item.

90A PREVIOUS CORRESPONDENCE - MUTUAL INFORMATION
90A This claim has been assessed in accordance with correspondence or telephone call.

90D ADJUSTMENT, RECIPIENT NO LONGER ELIGIBLE FOR COVERAGE
90D This is an adjustment to update your records only. Payment has not been
90D deducted from your account.
90D NOTE: The patient is not eligible for Alberta Health Care coverage for the
date of service and will be billed by Alberta Health Care.

90E ADJUSTMENT, RECIPIENT DECEASED
90E This is an adjustment to a previously assessed claim. Our records indicate
90E that the patient's date of death is prior to the date of service of the
90E claim. Please check your records to confirm the date of service. If the
90E wrong date of service was used, submit a change transaction with the
90E correct date of service.

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

95A INPATIENT/OUTPATIENT SERVICES
95A Payment was refused as an inpatient and an outpatient service provided at
95A the same hospital on the same day to an individual patient is not payable.

95B DAY OF DISCHARGE
95B Payment has been reduced as standard ward rate is not payable for the day of
95B discharge.

95C HIGH COST PROCEDURE/ZERO WARD RATE
95C Payment has been refused as when a high cost procedure and an inpatient
95C standard ward rate are being claimed, two separate claims must be submitted:
95C a) one claim showing the admission and discharge date and an inpatient
95C standard ward rate, with the claimed amount of zero, and
95C b) the other claim for the high cost procedure.

95D MULTIPLE TRANSPLANTS SAME HOSPITAL STAY
95D Payment has been refused as multiple same organ transplants within the same
95D hospital stay are not payable.

95E REDUCED BENEFITS
95E Payment has been reduced as the number of days between the admit date and
95E discharge date do not agree with the claimed amount.

95F OUTPATIENT SERVICES
95F Payment has been refused as an outpatient hospital service has been
95F previously paid for this patient for this date of service.

95G MAXIMUM NUMBER OF SERVICES
95G Payment has been refused as the maximum number of services was paid.

95K CLAIM IN PROCESS
95K Hold for documentation

95L OUT OF PROVINCE REGISTRATION EXPIRY DATE
95L Payment has been refused as the out of province registration expiry date on
95L the claim must be blank if the out of province registration number is blank.

95M UNABLE TO PROCESS UPDATED TRANSACTION
95M The transaction to update a previously submitted claim cannot be processed
95M  as:
95M  (a) the original add transaction cannot be located or
95M  (b) the result of your original claim is unknown, or
95M  (c) the original claim was previously deleted.
95M  Please review your records and resubmit, if applicable.

95T  INVALID ICD10CA DIAGNOSTIC CODE
95T  Payment was refused as the diagnostic code on the claim is invalid.
95T  Effective April 1, 2002 date of service, only the International Statistical
95T  Classification of Diseases and Related Health Problems, 10th Canadian
95T  Revision, diagnostic codes (ICD10CA) are acceptable for hospital reciprocal
95T  inpatient billing.

96A  MOTHER/NEWBORN REGISTRATION NUMBER
96A  This is an adjustment of a previously processed claim. Payment was deducted
96A  as the mother's out of province registration number may not be used for a
96A  baby over the age of three months. Please obtain the baby's correct out of
96A  province number and resubmit the claim.

96B  DECLARATION FORM INCOMPLETE/INCORRECT
96B  This is an adjustment of a previously processed claim. Payment was deducted
96B  as the Declaration Form requested by the patient's home province was:
96B  a) not provided or
96B  b) incomplete or
96B  c) not signed by the patient or parent/guardian

96C  OUT OF PROVINCE PATIENT INFORMATION/CLAIM INFORMATION DISCREPANCY
96C  This is an adjustment of a previously processed claim. Payment was deducted
96C  because there is a discrepancy between:
96C  a) the home province's patient registration information and the patient
96C  information on the claim; or
96C  b) the expiry date on the patient's health card and the expiry date on the
96C  claim.

96D  OUT OF PROVINCE PATIENT'S COVERAGE NOT EFFECTIVE
96D  This is an adjustment of a previously processed claim. Payment was deducted
96D  as the patient's home province has verified that the patient's health card
96D  was not valid on the:
96D  a) date of service or
96D  b) admission date or
96D  c) discharge date.

96E  INCORRECT CLAIM - ALBERTA RESPONSIBILITY
96E  Our records indicate that the patient was an Alberta resident on the date of
96E  service; therefore, this claim has been:
96E  A) refused, or
96E  B) adjusted from your previous payment.

96F  WORKERS' COMPENSATION BOARD RESPONSIBILITY
96F  This is an adjustment of a previously processed claim. Payment was deducted
96F  as we have received information advising this service is the responsibility
96F  of the Workers' Compensation Board. This claim should be submitted directly
96F  to the Workers' Compensation Board.
INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED
This is an adjustment of a previously processed claim. Payment was deducted at the request of the patient’s home province as an incorrect:
a) service or
b) date of service or
c) rate
was claimed. Please resubmit a new claim using the correct information, if applicable.

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

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

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

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

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

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

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

OTHER INTERVENTIONS - NON-ENROLLED PATIENTS
This transaction was refused as services defined as other interventions may not be submitted for non-enrolled patients. For a definition of other interventions, refer to the APP information in your Physician's Resource Guide.
98D Guide.

98DA OTHER INTERVENTIONS NOT ELIGIBLE UNDER GOOD FAITH
98DA This transaction was refused as services defined as other interventions may
98DA not be claimed under the Good Faith program. For a definition of other
98DA interventions, refer to the APP information in your Physician's Resource
98DA Guide.

98DB INELIGIBLE OTHER INTERVENTIONS
98DB This transaction was refused as this other intervention service may not be
98DB claimed under this Alternate Payment Plan program. For a definition of
98DB other interventions, refer to the APP information in your Physician's
98DB Resource Guide.

98DC DATE OF SERVICE / ALTERNATE PAYMENT PLAN EFFECTIVE DATE
98DC This transaction was refused as the Alternate Payment Plan program is not
98DC active for this date of service.

98E INVALID PAY-TO CODE
98E This transaction was refused as the pay-to code must be "BAPY" (Business
98E Arrangement Payee) for all Alternate Payment Plan services.

98EA INVALID HEALTH SERVICE CODE - NON-PATIENT SPECIFIC ULI
98EA This transaction was refused as only health service codes that are defined
98EA as non-patient may be submitted under the non-patient specific Unique
98EA Lifetime Identifier. For a definition of non-patient, refer to the APP
98EA information in your Physician's Resource Guide.

98EB INVALID BUSINESS ARRANGEMENT NUMBER
98EB This transaction was refused as the Alternate Payment Plan business
98EB arrangement number must be used for all services listed as other
98EB interventions. For a definition of other interventions, refer to the APP
98EB information in your Physician's Resource Guide.

98F RECIPIENT ANNUAL CAPITATION LIMIT
98F This service event was reduced or applied at zero as the patient has reached
98F the annual capitation maximum amount payable under this Alternate Payment
98F Plan.