

Alberta Health Claims Submission Explanation Codes

01 NOT REGISTERED

01 We have no record of this person registered with this Personal Health
01 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
01A and the appropriate newborn code.

01B NON RESIDENT

01B We cannot confirm that this patient is a resident of Alberta. Please
01B 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
01C 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
01C residents covered by the federal government, such as RCMP, Canadian
01C Forces members or inmates in federal corrections facilities.

01C Refer to the practitioner resource guide for information regarding your
01C billing alternatives.

02 REGISTRATION NUMBER/PHN CONFLICT

02 The Health Registration Number and the Personal Health Number (PHN) used
02 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
03 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
04A 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
05AA 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

05C 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

05E 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

10AA type of service.

11 LOCUM BUSINESS ARRANGEMENT

11 This claim has been refused as the Business Arrangement does not include
11 a Business Arrangement Type of Locum.

20 INELIGIBLE SERVICES

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

20A THIRD PARTY SERVICES

20A Examinations or services required to provide reports or certificates
20A requested by a third party are not an insured service, eg:
20A Adoption Judicial Purposes
20A Attendance at Camp (examinations/procedures
20A Autopsies requested by police)
20A Employment Motor Vehicle License (except
20A Insurance/disability after the age of 74.5 years of age)
20A Family & Social Services Participation in Sports
20A University or other school Passport or Visa
20A entrance Immigration Requirements

20AB EXPERIMENTAL/RESEARCH SERVICES

20AB Payment was refused as the Alberta Health Care Insurance Plan does not pay
20AB benefits for services that are experimental and/or in the research stage.

20B R.C.M.P., ARMED FORCES AND FEDERAL PENITENTIARY

20B Members of the RCMP, Armed Services and inmates of a Federal Penitentiary
20B are not beneficiaries under the Plan.

20C PRACTITIONER BILLING FOR OWN FAMILY

20C Services provided to members of your family or yourself are not a benefit
20C under the Plan.

20D DENTAL CARE - ORAL SURGERY

20D This service is not an oral surgical procedure payable by the Plan.

20E BENEFIT GUIDE

20E This is an incorrect Health Service Code. Please refer to the Plan's
20E 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

21A Care) and Health Service Code submitted do not agree. Verify the

21A 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'

21AA Compensation Board claim.

21AB WORKERS' COMPENSATION BOARD CLAIM SUBMISSIONS

21AB Payment was refused as effective June 1, 2000 Workers' Compensation Board

21AB 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

21B Board. Please submit the claim directly to the appropriate Workers'

21B Compensation Board.

22 INELIGIBLE PATIENT

22 Our records indicate this claim is the responsibility of another Provincial

22 Medical Plan.

23 CONTRACT SERVICES

23 This service is payable only to practitioners who provide medical services

23 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

23A 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

25 Reciprocal Agreement. Your claim should be billed directly to the patient

25 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

25A services provided to an Alberta patient.

28 OPTED OUT PRACTITIONER

28 This service was provided by a Practitioner who has opted out of the

28 Alberta Health Care Insurance Plan and there is no indication that this

28 was an emergency service.

28 INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED

30 ADDRESS

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

30A PROVINCE CODE

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

30AA CITY NAME

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

30AB COUNTRY CODE

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

30AC POSTAL CODE

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

30B DATE OF BIRTH

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

30BA GENDER

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

30E SURNAME

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

30EA FIRST NAME

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

30EB MIDDLE NAME

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

30F PERSON TYPE

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

30G GUARDIAN/PARENT PERSONAL HEALTH NUMBER

30G This claim was refused as the Guardian/Parent Personal Health Number on the
30G 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

34ED Reference Segment must have a "CST1" Text Segment.

34F CHART NUMBER

34F The chart number information was not in alpha numeric characters. Only

34F 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

35 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 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

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
50BC 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/
51 or post-operative care.

51A UNILATERAL - BILATERAL PROCEDURES

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

51G SURGICAL ASSISTS

51G Payment was refused according to General 13, for one of the following
51G 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
51G circumstances.

52 PROCEDURES - RESUBMISSION

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

52A LACERATIONS

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

52B SAME PHYSICIAN - TWO FUNCTIONS

52B Payment was refused as only one benefit can be paid when both surgical
52B 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
53A 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
54 the delivery.

54A POST-NATAL MAXIMUM

54A Payment was refused as only one routine post-natal visit, per physician,
54A 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
54B major visit item.
- 54B (c) a 03.03B benefit may only be claimed for the pre-natal visits and may
54B not be claimed for date of service following a delivery.

56 PROCEDURE - VISIT

56 Payment was refused as:

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

56A MULTIPLE MINOR SURGICAL PROCEDURES

- 56A Payment was reduced to 75% as only the greater benefit is payable in full
56A when multiple minor surgical procedures are performed.

56B VARICOSE VEINS INJECTIONS

- 56B Payment was refused as the maximum for the Benefit Year (July 1 to June 30)
56B was paid.
56B The Schedule of Medical Benefits allows one initial 51.92A, three 51.92B's,
56B six repeat 51.92A's and up to eighteen 51.92B services for each patient per
56B Benefit Year.

56C TRAY SERVICES

- 56C Payment was reduced or refused according to Governing Rules 14.1, 14.2 and
56C 14.3 in the Schedule of Medical Benefits.

56D FIBREGLASS CAST

- 56D a) Payment was reduced to the equivalent rate of an application of a cast
56D health service code (07.53B or 07.53D) as the service was performed in
56D a nursing home, general or auxiliary hospital or a facility which has
56D a contract with a Regional Health Authority.
56D b) Payment was reduced by a rate equivalent to health service code 07.53B
56D or 07.53D as the benefit for the application of a cast is included in
56D the fracture reduction health service code.
56D c) Payment was reduced by a rate equivalent to a major tray service benefit
56D which was paid for health service code 07.53B or 07.53D as cast supplies
56D are included in the benefits for 07.53H and 07.53J.

58 TWO PROCEDURES - TWO SURGEONS

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

58A INCLUSIVE ANAESTHETIC BENEFIT

- 58A Payment was refused as pre-anaesthetic/post-anaesthetic visits are included
58A in the anaesthetic benefit.

58B LOCAL ANAESTHETIC

- 58B Payment was refused as only the greater is payable when both the local
58B anaesthetic and the procedure are claimed by the same practitioner.

58BA SIMULTANEOUS SURGERY

- 58BA Payment was refused as only the greater anaesthetic benefit is payable when
58BA two practitioners operate simultaneously.

58C 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:
60AA (a) the service does not meet the requirements of a consultation or
60AA (b) the referral was not from a physician or
60AA (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:
60E (a) another physician has claimed for the same service. Submit a new claim with a DSCH modifier according to General Rule 5.1 or
60E (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

64C applicable health service code. Unlisted procedures are to be claimed

64C 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

64D 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

64E 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

65 inpatient, registered outpatient, AACC or UCC patient are not payable

65 under the Schedule. Payment for these services is the responsibility of

65 the hospital/Regional Health Authority. This applies to both the technical

65 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

65AA for the same date of service are not payable in excess of the listed

65AA benefit for E1. Or

65AA (b) The greater benefit is paid when claims are submitted for Health

65AA 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

65AA 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

65AA are paid within a 14 day period.

65C DIAGNOSTIC ULTRASOUND

65C Payment was refused as when claims are submitted for the same date of

65C 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

65C greater of (a) and the greater of (b) when provided on the same date

65C of service. Or

65C (c) X258 is not payable in addition to X234, X235, X239A, X240, X241, X242,

65C 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. 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
67AB 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
67AD benefit, although the dates of service do not agree. If this is not a
67AD 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
67B received on this date at a different location/hospital. Verify the dates
67B 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
67D medical staff. A review of this assessment by the Assessment Advisory
67D Committee can be requested by submitting a new claim with relevant
67D information.

67DA RELATED ASSESSMENT

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

67DB FINAL ASSESSMENT

67DB This claim has been paid, reduced or refused as recommended by the
67DB 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
68 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
69 supporting documentation for special circumstances.

70 PRE/POST-OPERATIVE CARE

70 This claim was assessed in accordance with General Rule 16.1 in the
70 Schedule of Oral and Maxillofacial Surgery Benefits or General Rule 6.2 in
70 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/

- 70K reline or
 70K d) an oral examination is not payable if performed more than 365 days after
 70K a denture or reline benefit was provided.
- 70L DENTAL PROCEDURES
 70L Payment was refused as when multiple services are claimed for the same date
 70L of service, the following rules apply:
 70L (a) only the greater benefit of a minor procedure, consultation or any
 70L visit is payable when the services and diagnosis are related or
 70L (b) only the greater benefit of a minor (M or M+) procedure or a hospital
 70L visit is payable, regardless of the diagnosis or
 70L (c) only the greater benefit of a minor (M+) procedure or a visit is
 70L payable when performed in a location other than an Oral and
 70L Maxillofacial Surgeon's or Dentist's office, or surgical suite,
 70L regardless of the diagnosis or
 70L (d) an office visit benefit is not payable with a minor (M+) procedure and
 70L a consultation, regardless of whether the services are performed at
 70L different encounters.
- 72 AHC AND WCB CLAIM FOR THE SAME VISIT
 72 Payment was refused as a benefit was paid for a Workers' Compensation Board
 72 claim.
- 72C WORKERS' COMPENSATION BOARD RESPONSIBILITY
 72C Payment was refused as the Workers' Compensation Board will not accept
 72C responsibility for this service.
- 72D WORKERS' COMPENSATION BOARD
 72D The Workers' Compensation Board has accepted responsibility for this claim.
 72D ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6
- 73 ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6
 73 Payment was refused as non-residents, Allied Health Providers and subscriber
 73 claims do not qualify for additional benefits under GR 2.6.
- 73A ADDITIONAL COMPENSATION COMMITTEE/ ASSESSMENT ADVISORY SUBCOMMITTEE
 73A ASSESSMENT
 73A This claim was paid, reduced or refused as recommended by the Additional
 73A Compensation Committee or Assessment Advisory Subcommittee.
- 73BA INCORRECT ADDITIONAL COMPENSATION CLAIM SUBMISSION
 73BA Payment was refused as the claim for additional compensation was submitted
 73BA incorrectly. Refer to the Physician's Resource Guide and resubmit
 73BA appropriately.
- 73BB NO PAYMENT BY ALBERTA HEALTH INSURANCE PLAN
 73BB Payment of the additional compensation portion of the claim was refused as
 73BB there is no record of an Alberta Health Care Insurance Plan payment for this
 73BB service.
- 73BC REQUEST FOR ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6
 73BC Payment was refused as supporting documentation is required for the
 73BC 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

80BB default price adjustment mechanism in fiscal year 2002/2003.

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
80C payment may be reviewed at a later date if we receive changes to
80C 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
80C 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
80CA limit allowed for this date of service.

80D EYEGASSES/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
80F 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
80J 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
80L 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
90A 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 that the patient's date of death is prior to the date of service of the claim. Please check your records to confirm the date of service. If the wrong date of service was used, submit a change transaction with the correct date of service.

95 NEWBORN

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

95A INPATIENT/OUTPATIENT SERVICES

95A Payment was refused as an inpatient and an outpatient service provided at 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 discharge.

95C HIGH COST PROCEDURE/ZERO WARD RATE

95C Payment has been refused as when a high cost procedure and an inpatient 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 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 hospital stay are not payable.

95E REDUCED BENEFITS

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

95F OUTPATIENT SERVICES

95F Payment has been refused as an outpatient hospital service has been 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 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.

96G INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

96G This is an adjustment of a previously processed claim. Payment was deducted at the request of the patient's home province as an incorrect:

96G a) service or

96G b) date of service or

96G c) rate

96G was claimed. Please resubmit a new claim using the correct information, if applicable.

96H SECOND OUT-PATIENT VISIT

96H 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.

96H Note: Charges for additional out-patient visits may not be billed directly to the patient or home province.

97A INCORRECT SERVICE/DATE OF SERVICE/RATE CLAIMED

97A This is an adjustment of a previously processed claim. Payment was deducted at the request of the Alberta RHA/hospital as an incorrect:

97A a) service or

97A b) date of service or

97A c) rate

97A was claimed. Please resubmit a new claim using the correct information, if applicable.

98 CAPITATION PAID

98 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.

98A INVALID HEALTH SERVICE CODE

98A Payment was refused as this health service code may not be claimed by the business arrangement number indicated on the claim.

98AA FFS/APP Reassessed Claims

98AA 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.

98B NON-PATIENT SPECIFIC ULI - OTHER INTERVENTIONS

98B 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.

98C LOCUM BUSINESS ARRANGEMENT - FEE FOR SERVICE

98C 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.

98D OTHER INTERVENTIONS - NON-ENROLED PATIENTS

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

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.

98DC INCOMPLETE CLAIMS / ADDITIONAL INFORMATION REQUIRED

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.