RSC ECO CMG03
Fall 2023 Meeting Minutes
October 3, 2023, 10:00 EST

- Claim Adjustment Reason Codes (External Code List 139)
  - Review of requests: 368, 372, 374, 376, 394
- Health Care Claim Status Category Codes (External Code List 507)
  - Review of request: 1044
- Health Care Claim Status Codes (External Code List 508)
  - No requests

Old Business:
None

New Business:
Claim Adjustment Reason Codes (External Code List 139)

1. **Request 368**
   Request Type: New CARC
   Justification: Some of our health plan clients are denying institutional home health claims using CO 45 when the type of bill frequency code is 9 (final claim) and the patient status is 30 (still patient). CO 45 is not accurate and should not be used for total billed charges, so we have to call to inquire about the real issue. We can use CARC 16 (Billing errors) with RARC MA43 (Missing/incomplete/invalid patient status) but perhaps the frequency code is what needs to be changed, not the status. The requested CARC would better explain to providers what the issue is and what needs to possibly be corrected.
   Requested Description: Frequency code is inconsistent with the patient status
   Motion: Motion and second to approve with following wording: *Type of bill is inconsistent with the patient status. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*
   Approve: 9 **Disapprove:** 0 **Abstain:** 0

2. **Request 372**

Request Type: New CARC

Justification: Currently the only code available for a claim denial like this is 29 (The time limit for filing has expired). There is a difference between timely filing and usage of a delay reason code. The main difference between these two concepts is that timely filing for delay reason code use allows for the late filing of a claim if the provider can justify the delay with a valid delay reason code. Timely filing exceeding a time period, on the other hand, generally does not allow for the late filing of a claim, regardless of the reason for the delay. CARC 29, we feel, only speaks to timely filing, and there is no other option (DRC use). Frequently, providers contact claims support to find out that the filed within the time limit (1 or 2 years) but MAY be able to submit with a DRC. CARC 29 does not relay that option very well. There also does not seem to be a RARC to pair with either CARC 29 or a new CARC.

Requested Description: The claim does not meet the criteria for acceptable use of the submitted Delay Reason Code.

Motion: Motion and second to deny with recommendation to use CARC 16 and 29 and request a new RARC.

Approve: 9 **Disapprove:** 0 **Abstain:** 0

3. **Request 374**

Request Type: Revise the description of an existing code – A1

Justification: The description contains wording about a pending update even though the date has passed.

Requested Description: Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.

Motion: Motion and second to approve. This is an administrative issue and publisher should look at entire code list to remove any items with future date references.

Approve: 9 **Disapprove:** 0 **Abstain:** 0

4. **Request 376**
   Request Type: New CARC
   Justification: We are faced with a challenge to pass information on the encounter of how the claim was adjudicated by the delegate related to the No Surprise Act. This information needs to be generated on the member EOB at the health plan.
   Requested Description: No Surprise Act payment reduction
   Motion: Motion and second to table.
   Approve: 9 **Disapprove:** 0 **Abstain:** 0

5. **Request 394**
   Request Type: New CARC
   Justification: Under the federal no surprises act the member's cost-share is determined according to the qualifying payment amount for either the HCPCS or CPT code, which would be assigned a RARC code. However, if the claim is an inpatient hospital bill then the cost-share is rolled up to the claim level and determined at the DRG level. A CARC needs to be assigned for this scenario
   Requested Description: The member's cost-share has been calculated according to the methodology for the qualified payment amount for the No Surprises Act for the inpatient hospital DRG claim.
   Motion: Motion and second to deny. A new RARC should be requested.
   Approve: 9 **Disapprove:** 0 **Abstain:** 0

Health Care Claim Status Category Codes (External Code List 507)

6. **Request 1044**
   Request Type: New Category Code
   Justification: UHC requires delegates to pass information on the encounters where services may qualify for Surprise Medical Billing. Creating a new edit will help us enforce this requirement.
   Requested Description: Surprise Medical Billing (SMB) information is missing or invalid
   Motion: Motion and second to deny. Request submitted for CSGC not CSC in error.
   Approve: 9 **Disapprove:** 0 **Abstain:** 0

Next meeting: Interim - October 30, 2023; Winter Standing

Meeting adjourned: 10:47