RSC ECO CMG03
Winter 2022 Meeting Minutes
January 25, 2022, 9:00 am CT

- Claim Adjustment Reason Codes (External Code List 139)
  - Review of requests 246, 247, 251 and 252
- Health Care Claim Status Category Codes (External Code List 507)
  - No requests received
- Health Care Claim Status Codes (External Code List 508)
  - Review of requests 52, 56, 61 and 62

Old Business:
None

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

1. **Request 246**
   Request Type: Revise the description of an existing code CARC 249
   Justification: I believe the description is incorrect.
   Requested Description: 249 description reads, "This claim has been identified as a readmission", shouldn't it read "This claim has been identified as a resubmisison"?
   Motion: Motion and second to deny and to revise description to include the required RARC statement and use of group code CO only.
   Approve: 8 **Disapprove:** 0 **Abstain:** 0

2. **Request 247**
   Request Type: Add a new CARC code
   Justification: CARCs currently exist to notify providers of re-routed/forwarded claims for dental (291), pharmacy (292), vision (298), and behavioral health (300) claims. As an MAO plan, we are required by CMS to also forward medical claims, such as specialist or therapist claims. Is there a code to use for medical or can one be created

Requested Description: Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical delegated health plan for further consideration.
Motion: Motion and second to table for follow-up with requestor.
Approve: 8 **Disapprove:** 0 **Abstain:** 0

3. **Request 251**
Request Type: Add a new CARC code
Justification: This is needed to help further define what payer may cover the services billed other than the medical payer. This is similar to 270, 280, 297
Requested Description: CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. SUBMIT THESE SERVICES TO THE PATIENT'S HEARING PLAN FOR FURTHER CONSIDERATION.
Motion: Motion and second to approve.
Approve: 8 **Disapprove:** 0 **Abstain:** 0
Approved Description: Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's hearing plan for further consideration.
Code number to be assigned
Effective Date: August 1, 2022

Motion: Motion and second to approve additional code.
Approve: 8 **Disapprove:** 0 **Abstain:** 0
Approved Description: Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's hearing plan for further consideration.
Code number to be assigned
Effective Date: August 1, 2022

4. **Request 252**
Request Type: Add a new CARC code
Justification: Kansas Medicaid has a special member responsibility for HCBS services. Properly defining this in the claim adjudication will allow the providers to easily identify this and properly bill the member.
Requested Description: Client Obligation, the patient must pay this amount to their provider(s) for Home & Community Based Services (HCBS)
Motion: Motion and second to deny. Additional recommendation: use CARC 142 and request new RARC.
Approve: 8 **Disapprove:** 0 **Abstain:** 0

5. **Request 52**
   Request Type: New Health Care Claim Status
   Justification: In some cases, for corrected claim/adjustments scenarios, the original claim is updated with data from the adjustment claim and reopened for processing. There is not a current status code that reflects that scenario specifically.
   Requested Description: Adjustment will be made to original claim.
   Motion: Motion and second to deny.
   Approve: 8 **Disapprove:** 0 **Abstain:** 0

6. **Request 56**
   Request Type: Add a new Health Care Claim Status Code
   Justification: The Ohio Department of Medicaid (ODM) is implementing a new claims adjudication system which will allow for scenario 2 but there is not currently a claim status code in the external code list 508 to communicate to the submitter that the withdrawal/void claim was accepted and that further processing on the original claim has been discontinued.
   Our request provides a means to communicate the X12 response for RFI #2060 Scenario #2
   Requested Description: A claim requesting a withdraw/void of a previously submitted claim was received and accepted before the original claim had completed processing. Therefore, no further processing will be performed on either submission. The provider should consider both claims as cancelled.
   Motion: Motion and second to deny.
   Approve: 8 **Disapprove:** 0 **Abstain:** 0

7. **Request 61**
   Request Type: Healthcare Claim Status Code Deactivation
   Justification: This new code (797) was created from the September 2021 standing meeting, but should have been a modification to existing status code 134. The original request (Maintenance Reqest Number 55) was to modify status code 134 description to "Entity's TRICARE provider id. Usage: This code requires use of an Entity Code." CMG03 adjudicated and approved the modification on September 28, 2021; however, it was published as a new code. This request is to deactivate 797.
   Requested Description: N/A
   Motion: Adjudicated with Request 62

Approve: 8 **Disapprove:** 0 **Abstain:** 0

8. **Request 62**
   Request Type: Healthcare Claim Status Code Description Modification
   Justification: This request is to modify 134 as originally requested (MR #55), adjudicated and approved by CMG03 on September 28, 2021.
   The approved modification was published as a new code (797). An additional request has been added to deactivate 797.
   Requested Description: Entity's TRICARE provider id. Usage: This code requires use of an Entity Code.
   Motion: Motion and second to approve Reqest 61 and 62.
   Approve: 8 **Disapprove:** 0 **Abstain:** 0
   Code number to be assigned
   Effective Date: August 1, 2022

Next meeting: Summer 2022

Meeting adjourned: