Explanatory Code List

As Of

01 April 2024

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ACRONYMS AND SPECIAL PROCESSING CODES

Advanced Ambulatory Care Centre (AACC)
Alberta Health Care Insurance Plan (AHCIP)
Alternate Payment Plan (APP)
Business Arrangement (BA)
Extended Health Benefits (EHB)
Fee for Service (FFS)
Health Service Code (HSC)
Personal Health Number (PHN)
Practitioner Identifier (PRAC ID)
Regional Health Authority (RHA)
Unique Lifetime Identifier (ULI)
Urgent Care Centre (UCC)
Workers' Compensation Board (WCB)

INFRC RECOVERED FROM INCOMING FUND

This amount was deducted from the funds you previously sent to Alberta Health and Wellness. These funds may be a premium or claim payment.

RTRF REASSESS TRANSACTION REFUSED

Your reassess transaction was reviewed and did not result in a change to the original payment and therefore was refused.

RVRSL REVERSAL

This is a reversal of a previously assessed item.

PATIENT REGISTRATION

01 NOT REGISTERED

We have no record of this person registered with this PHN.

01A NOT REGISTERED

This person is not registered with the AHCIP. If the patient is a newborn, submit a new claim with a Person Data Segment and the appropriate newborn code.

01B NON RESIDENT

We cannot confirm that this patient is an Alberta resident. Please contact the patient to obtain the correct billing information.

PATIENT REGISTRATION (cont'd)

01C GOOD FAITH CLAIM

Payment was refused as:

a) a Good Faith claim was previously paid for this patient; therefore, this patient does not qualify for further Good Faith claim processing or
b) Good Faith claims are not payable for visitors to Alberta or for residents covered by the federal government, such as Canadian Forces members or federal penitentiary inmates.

Refer to the applicable Resource Guide for information regarding billing alternatives.

02 REGISTRATION NUMBER/PERSONAL HEALTH NUMBER CONFLICT

The health registration number and the PHN submitted are not for the same person.

03 NEWBORN

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

04 DONOR'S PERSONAL HEALTH NUMBER USED

Submit this claim using the PHN of the donor recipient.

04A CHANGED PERSONAL HEALTH NUMBER

This is the correct PHN for this patient. All new claims for this patient should be submitted with this PHN.

05 PATIENT PERSONAL HEALTH NUMBER - NOT EFFECTIVE

This PHN is not effective for the date(s) of service submitted.

05A INVALID PERSONAL HEALTH NUMBER

The PHN is invalid or blank.

05AA OPTED OUT RESIDENT

The patient has opted out of the AHCIP. The patient has agreed to assume financial liability for all health services. Please contact your patient regarding payment for your services.

PATIENT REGISTRATION (cont'd)

05B UNREGISTERED WORKERS' COMPENSATION BOARD CLAIM

The patient is not eligible for AHCIP coverage for the date(s) of service. Submit your claim directly to the WCB.

05BA INVALID/BLANK REGISTRATION NUMBER

This claim was refused as the registration number is:

(a) blank or
(b) invalid.

05BB INVALID/BLANK UNIQUE LIFETIME IDENTIFIER

This claim was refused as the ULI is:

(a) blank or
(b) invalid or
(c) not valid for the service recipient.

05C ELIGIBILITY EXTENDED HEALTH BENEFITS PROGRAM

The patient did not have coverage under the EHB Program for the date of service submitted.

06 RETROACTIVE ELIGIBILITY CHANGE

Your request to change or reassess this claim was refused. Due to a retroactive eligibility change, the patient is not eligible for AHCIP coverage for this date of service.

07 NEW RECIPIENT FOR ALTERNATE PAYMENT PLAN CONTRACT

Your claim for a new recipient was paid as a FFS benefit.

08 NEW RECIPIENT PREVIOUSLY PAID FOR ALTERNATE PAYMENT PLAN CONTRACT

Payment was refused as a FFS benefit was previously paid for a new recipient.

09 INITIAL ROSTER RELATIONSHIP

Payment was refused as an Initial Roster relationship exists for this patient. Therefore, a FFS benefit is not payable under a Temporary Roster relationship.

PATIENT REGISTRATION (cont'd)

PRACTITIONER REGISTRATION

10 INELIGIBLE PRACTITIONER/INCORRECT SUBMISSION

We have not received notification from the governing body/licensing association that the practitioner is approved to perform this service.

10A SERVICE PROVIDER RESTRICTIONS

Our records indicate that the service provider is:

(a) restricted to a specific facility or
(b) restricted to performing specific services.

10AA INELIGIBLE PRACTITIONER

This claim was refused as you are not entitled to payment for this type of service.

11 LOCUM BUSINESS ARRANGEMENT

This claim was refused as the BA does not include a BA type of locum.

INELIGIBLE SERVICES

20 INELIGIBLE SERVICES

Payment was refused as the services are not eligible for AHCIP coverage. Refer to the general rules in the applicable benefits schedule for examples of ineligible services.

20A THIRD PARTY SERVICES

Payment was refused as these are considered to be third party services. Refer to the general rules in the applicable benefits schedule for examples of third party services.

20AB EXPERIMENTAL/RESEARCH SERVICES

Payment was refused as the AHCIP does not pay benefits for services that are experimental and/or in the research stage.

INELIGIBLE SERVICES (cont'd)

20B ARMED FORCES AND FEDERAL PENITENTIARY

Armed forces members and federal penitentiary inmates are not eligible for AHCIP coverage.

20C PRACTITIONER BILLING FOR OWN FAMILY

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

20D DENTAL CARE - ORAL SURGERY

This service is not an oral surgical procedure payable by the AHCIP.

20E BENEFITS SCHEDULE

This is an incorrect HSC. Please refer to the applicable benefits schedule.

20F EXCLUDED ITEM

This service is not payable under the EHB Program.

21 WORKERS' COMPENSATION BOARD CLAIM

This claim was refused as:
(a) claim is responsibility of Workers' Compensation Board (WCB), or
(b) WCB has paid a claim for the same date of service. If this visit is unrelated to the WCB injury, submit a new claim with health service code 03.01J to Alberta Health.

21AB WORKERS' COMPENSATION BOARD CLAIM SUBMISSIONS

Payment was refused as WCB claims are to be submitted directly to the WCB.

21AC WORKERS'COMPENSATION BOARD SUPPORTING DOCUMENTATION REQUIRED

Both the WCB denial letter and online remittance are required.

22 INELIGIBLE PATIENT

Our records indicate this claim is the responsibility of another provincial health plan.

INELIGIBLE SERVICES (cont'd)

23A PRIOR APPROVAL

Payment was refused as:

(a) this service requires prior approval from the patient's provincial health plan and/or
(b) prior approval was not received for this date of service.

25 EXCLUDED SERVICE - RECIPROCAL PROGRAMS

Payment was 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

Payment was refused as you have submitted a medical reciprocal claim for services provided to an Alberta patient.

28 OPTED OUT PRACTITIONER

This service was provided by a practitioner who has opted out of the AHCIP and there is no indication that this was an emergency service.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED

Person Data Segment

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.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

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 or
(b) invalid or
(c) incomplete or
(d) after the date of service submitted.

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.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

30G GUARDIAN/PARENT PERSONAL HEALTH NUMBER

This claim was refused as the guardian/parent PHN on the Person Data Segment is invalid or blank.

30H GUARDIAN/PARENT HEALTH PLAN NUMBER

This claim was refused as the guardian/parent registration number on the Person Data Segment is invalid or blank.

31 INCOMPLETE PERSON DATA

This claim was refused as the Person Data Segment is:

(a) required or
(b) incomplete for the person type submitted or
(c) required as we have no record of the PHN which was submitted.

31A PERSON DATA SEGMENT CONFLICT

The out of province registration number and the Person Data Segment do not match the service recipient information in our files.

Confirm the patient's out of province health care card registration number, home province/recovery code, and personal data information with the patient or the patient's home provincial health plan. If applicable, submit a new claim with supporting text indicating that the physician has verified the patient's personal information.

Base Claim Batch Process

34AA CLAIM CURRENT YEAR SEGMENT

The current year indicated within the claim number is not numeric or not the current year.

34AB CLAIM SEQUENCE NUMBER

The claim sequence number indicated within the claim number is not numeric.

34AC CLAIM CHECK DIGIT

The check digit number indicated within the claim number is invalid.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

34AD ACTION CODE

The action code is inconsistent with other information segments within this transaction.

34B EXTRAORDINARY MEDICAL SERVICES ASSESSMENT FUND INDICATOR

The extraordinary medical services assessment fund indicator is invalid.

34C CLAIM RECORD TYPE

The record type is invalid. To process the claim the record type must be:

(a) number 2 in the batch header data field or
(b) number 3 in the claim detailed record field or
(c) number 4 in the batch trailer data field.

Refer to the Electronic Claims Submissions Specifications Handbook.

34DA CLAIM TRANSACTION TYPE

The transaction type is not CIP1. Refer to the Electronic Claims Submissions Specifications Handbook.

34DB CLAIM SEGMENT TYPE

The segment type must be:

(a) CIB1 - Claim Regular or
(b) CPD1 - Person Data Segment or
(c) CST1 - Text Segment or
(d) CTX1 - Text Cross Reference Segment or
(e) in proper order.

Refer to the Electronic Claims Submissions Specifications Handbook.

34DC SEGMENT SEQUENCE NUMBER

The segment sequence number is not incremental. Refer to the Electronic Claims Submissions Specifications Handbook.

34DD CST1 SEGMENT REQUIRED

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

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

34DE MAXIMUM CST1 SEGMENT

The maximum number of CST1 segments (500) was exceeded.

34DF CIB1 SEGMENT REQUIRED

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

34DG CPD1 SEGMENT NOT ALLOWED

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

34DH MAXIMUM CPD1 SEGMENT

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

34EA CLAIM TEXT SEGMENT

The text information you supplied is not in alpha numeric format.

34EB CLAIM SOURCE CODE

The claim source code is invalid. Refer to the Electronic Claims Submissions Specifications Handbook.

34EC SUPPORTING TEXT CROSS REFERENCE

The Supporting Text Cross Reference segment claim(s) number has failed the claim check algorithm. Refer to the Electronic Claims Submissions Specifications Handbook.

34ED CTX1 AND CST1 SEGMENT

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

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

34F CHART NUMBER

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

Base Claim Segment

35 ACTION CODE

This transaction was refused as:

(a) the Action Code is invalid or
(b) Action code "R" (Reassess) is only allowed if text is submitted and the original HSC which was reduced requires reassessment or
(c) Action Code "D" (Delete) cannot be processed when the Pay To Code is not "BAPY" or
(d) Action Code "C" (Change) cannot be processed on a refused claim.

35A INTERCEPT

The intercept code is invalid.

35B RECOVERY CODE

The recovery code is invalid or not allowed for this BA.

35C REASSESS REASON CODE

The reassess reason code is invalid or blank.

35D CLAIM TYPE

The claim type is invalid or blank.

35E CONFIDENTIAL INDICATOR CODE

The confidential indicator code is invalid.

35F CLAIM NUMBER

The claim number is invalid or blank.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

35FA SUBMISSION OF A CLAIM NUMBER

The claim number submitted was previously used on:

(a) refused claim or
(b) claim which is being held or
(c) a paid service event or claim applied at a zero amount.

35FB UNABLE TO PROCESS UPDATED TRANSACTION

The transaction to update a previously submitted claim cannot be processed as:

(a) the original add transaction cannot be located or
(b) the result of your original claim must be known or
(c) the original claim was previously deleted.

35FC UNABLE TO PROCESS ADD TRANSACTION

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

35G GOOD FAITH INDICATOR

The good faith indicator is invalid.

35H SUPPORTING DOCUMENTATION INDICATOR

The supporting documentation indicator is invalid.

35J TEXT INDICATOR

The text indicator is invalid.

35K PAY TO CODE

The pay to code is invalid or cannot be changed.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

35KA PAY TO CODE/PAY TO UNIQUE LIFETIME IDENTIFIER CONFLICT

There is a conflict between the information shown in the pay to code and the pay to ULI. When the pay to code is "OTHR" (other) the pay to ULI cannot be:

(a) the service provider or
(b) the BA payee or
(c) the patient or
(d) the Alberta Health and Wellness registration account holder responsible for the patient.

35L PAY TO UNIQUE LIFETIME IDENTIFIER

The pay to ULI is invalid or blank.

35M NEWBORN CODE

The newborn code is invalid or not required when the patient's PHN is already provided.

36 LOCUM BUSINESS ARRANGEMENT

The locum BA number is invalid or not required.

36A LOCUM/BUSINESS ARRANGEMENT NUMBERS

The locum BA and the BA fields were not completed properly. Please refer to the Physician's Resource Guide and submit a new claim.

37 BUSINESS ARRANGEMENT

The BA number is:

(a) invalid or blank or
(b) restricted to performing specific services or
(c) restricted to performing services at a specific facility or
(d) not registered with the submitter of the transaction or
(e) restricted to patients from a specific area or
(f) does not have a relationship with the practitioner identifier submitted.

37A PRACTITIONER IDENTIFIER

The PRAC ID is blank, invalid or not effective for the date of service.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

37B SKILL CODE

The skill code is invalid or blank.

39 DATE OF SERVICE

The date of service is:

(a) invalid or blank or
(b) more than one year from date of birth (newborn) or
(c) in conflict with the explicit modifier indicated.

39A DATE OF SERVICE CONFLICT

The date of service on the claim and the date of service indicated on the supporting documentation do not match.

39B HEALTH SERVICE CODE

Payment has been refused as the HSC is:

(a) blank or invalid or
(b) not listed in the applicable benefits schedule.

39BA GENDER RESTRICTION

The HSC and/or diagnosis does not agree with the gender of the patient.

39BB AGE RESTRICTION

The patient is not eligible for this service due to age.

39BC HEALTH SERVICE CODE NOT APPROPRIATE FOR DIAGNOSIS

The HSC does not agree with the diagnosis.

39BD DATE OF SERVICE/HEALTH SERVICE CODE DATE CONFLICT

The HSC is not effective on this date of service.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

39BE CONCEPTUAL/CORRECTED AGE

Payment for the additional benefit was refused as the patient is not eligible due to age.

39C NUMBER OF CALLS

This claim was refused as:

(a) the number of calls is invalid or blank or
(b) the number of calls is more than the number allowed for this service.

If applicable, resubmit the claim with supporting text.

39D LOCATION OF SERVICE

The location of service is not appropriate for the HSC.

39DA FACILITY NUMBER

The facility number is invalid or blank.

39DB FUNCTIONAL CENTER CODE

The functional center:

(a) is blank or invalid or
(b) is not appropriate for the service submitted or
(c) does not exist for the facility submitted.

39DC ORIGINATING FACILITY NUMBER

The originating facility number is invalid or blank.

39DD ORIGINATING LOCATION

The originating location code is:

(a) invalid or blank or
(b) not required when the originating facility number is submitted.

39DE ORIGINATING FACILITY NUMBER/LOCATION FOR PATHOLOGY SERVICES

The originating facility number or the originating location code is required for pathology services (E HSCs).

39EB DIAGNOSTIC CODE

The diagnostic code is blank or invalid.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

39EC HEALTH SERVICE CODE AND DIAGNOSTIC CODE CONFLICT

The claim was refused as the HSC and the diagnostic code are in conflict.

39F USE CLAIMED AMOUNT INDICATOR

The use claimed amount indicator is invalid.

39FA AMOUNT CLAIMED/USE CLAIMED AMOUNT INDICATOR

Your claim was refused as:

(a) the amount claimed is blank. Claims for unlisted procedures (HSCs in the 99.09 series) require a claimed amount and a "Y" in the claimed amount indicator field or
(b) the amount claimed is blank or invalid and the claimed amount indicator is "Y" or
(c) the amount claimed is completed, but the claimed amount indicator is blank or invalid.

39G MODIFIER CODE

The modifier code:

(a) is required with the HSC submitted or
(b) is invalid or
(c) can only have one modifier of the same type or
(d) cannot have this combination of modifiers or
(e) must have a valid two digit numeric suffix when modifier type is SURT or
(f) exceeded the maximum number of time units allowed for the modifier type SURT.

39H TELEHEALTH SERVICES

This claim was refused as the HSC and the modifier code are in conflict because:

(a) the STFO modifier applies only to teledermatology and HSC 03.09B or
(b) the TELES modifier is not attached to this HSC.

41 DOCUMENTATION INCOMPLETE/NOT RECEIVED

The supporting documentation for this claim was incomplete or not received.

41B TIME/SITES - EXTENDED HEALTH BENEFITS

Submit a new claim indicating the number of units, quadrants or sextants.

INCOMPLETE CLAIMS/ADDITIONAL INFORMATION REQUIRED (cont'd)

42 HOSPITAL ADMISSION/ORIGINATING ENCOUNTER DATE

The hospital admission/originating encounter date is invalid or blank.

43 OUT OF PROVINCE HEALTH PLAN NUMBER

The out of province health plan number is invalid or blank.

45 INVALID REFERRING PRACTITIONER IDENTIFIER

The Referring Prac ID is:

(a) blank or invalid or
(b) not an intraspecialty or
(c) from a practitioner without the appropriate discipline or skill.

45A OUT OF PROVINCE REFERRAL INDICATOR

The out of province referral indicator is invalid.

45AA REFERRAL PRACTITIONER IDENTIFIER INVALID/INABLE TO RESOLVE

Your claim was refused as the referral PRAC ID is invalid. Contact the referring practitioner for the correct PRAC ID.

45B ENCOUNTER NUMBER

The Encounter number is invalid.

47 SERVICE RECIPIENT PERSONAL HEALTH NUMBER

This claim was refused as the service recipient PHN cannot be changed. Delete the original claim and submit a new claim with the correct PHN.

48 PRACTITIONER IDENTIFIER

This claim was refused as the PRAC ID cannot be changed. Delete the original claim and submit a new claim with the correct PRAC ID.

49 BUSINESS ARRANGEMENT/LOCUM BUSINESS ARRANGEMENT NUMBER

This claim was refused as the BA and/or locum BA number cannot be changed. Delete the original claim and submit a new claim with the correct BA or Locum BA number.

SURGICAL PROCEDURES

SURGICAL PROCEDURES (cont'd)

50 TWO PHYSICIANS - UNRELATED ABDOMINAL SURGICAL PROCEDURES

Payment was reduced to 75% of the benefit as the full benefit for the major procedure was paid to the physician most responsible for the patient's care.

50A PROCEDURES INCLUDED IN THE MAJOR PROCEDURAL BENEFIT

Payment was refused as this service is included in the benefit paid for the major procedure.

50AA DIAGNOSTIC PROCEDURES RELATING TO SURGERY

Payment was refused as the diagnostic procedure is included in the benefit paid for the surgical procedure when performed under the same anesthetic.

50AB SECOND OR SUBSEQUENT PROCEDURE

Payment for the procedure was reduced to 50% as this service was performed as a second or subsequent procedure through the same incision.

50B REPEAT CLOSED REDUCTION - SAME PRACTITIONER

Payment was refused as a repeat closed reduction performed by the same practitioner is not payable.

50BA REPEAT CLOSED REDUCTION - DIFFERENT PRACTITIONER

Payment was reduced to 50% as a different practitioner performed a repeat closed reduction for the same fracture or dislocation.

50BB CLOSED - OPEN REDUCTION - DIFFERENT PRACTITIONER

Payment was reduced to 50% as a different practitioner performed an open reduction for the same fracture.

50BC CLOSED - OPEN REDUCTION - SAME PRACTITIONER

Payment was refused as a closed reduction is not payable when the same practitioner performs an open reduction for the same fracture under the same anesthetic.

51 PRE AND/OR POST-OPERATIVE CARE - TWO PRACTITIONERS

Payment was reduced or refused as another Practitioner was paid for pre-and/or post-operative care.

51A UNILATERAL - BILATERAL PROCEDURES

Payment was reduced as the benefit does not increase when a bilateral procedure is performed.

SURGICAL PROCEDURES (cont'd)

51G SURGICAL ASSISTS

Payment was refused as:

(a) a surgical assist benefit is not payable for the procedure submitted or
(b) a surgical procedure was not claimed for this date of service or
(c) documentation was not submitted to support a claim involving unusual circumstances.

52A LACERATIONS

Payment was made according to the explanation following HSC 98.22B.

52B SAME PHYSICIAN - TWO FUNCTIONS

Payment was refused as only one benefit can be paid when both surgical and anesthetic services are performed by the same physician.

54 INCLUDED SERVICES

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

54A POSTNATAL MAXIMUM

Payment was refused as only one routine postnatal visit per physician is payable.

54B PRENATAL CARE

Payment was refused as:

(a) only one HSC 03.04B may be claimed per pregnancy per physician or
(b) 03.04B may not be claimed within 91 days of a major visit HSC or
(c) 03.03B may only be claimed for the prenatal visits and not for dates of service following a delivery.

MINOR PROCEDURES

56 PROCEDURE - VISIT

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.

MINOR PROCEDURES (cont'd)

56A 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.

56B VARICOSE VEINS INJECTIONS

Payment was refused as the maximum for the benefit year (July 1 to June 30) was paid.

56C TRAY SERVICES

Payment was reduced or refused according to the applicable benefits schedule.

56D FIBREGLASS CAST

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

ANESTHESIA

58 TWO PROCEDURES - TWO SURGEONS

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

58A INCLUSIVE ANESTHETIC BENEFIT

Payment was refused as pre- and/or post-anesthetic visits are included in the anesthetic benefit.

58B LOCAL ANESTHETIC

Payment was refused as only the greater benefit is payable when both the local anesthetic and the procedure are claimed by the same practitioner.

58BA SIMULTANEOUS SURGERY

Payment was refused as only the greater anesthetic benefit is payable when two practitioners operate simultaneously.

ANESTHESIA (cont'd)

58C MULTIPLE BENIGN SKIN LESIONS

Payment was reduced or refused as only a single anesthetic benefit is payable when surgical treatment of multiple benign skin lesions is performed under anesthetic of less than 35 minutes duration.

58E RELATED ANESTHETIC CODE

Payment was made according to the information submitted on the surgeon's claim.

58F ADDITIONAL AGE BENEFIT

Payment was reduced as only one additional anesthetic benefit per case is payable regardless of the number of anesthetic services provided.

CONSULTATIONS/VISITS

60 INITIAL VISIT - MAJOR

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

Payment was refused as a consultation benefit is included in the procedural benefit.

60AA CONSULTATION

Payment was reduced to the rate payable for a non-referred visit HSC as:

(a) the service does not meet the requirements of a consultation or
(b) the referral was not from a physician, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner, or
(c) the referral was from a family member.

60B DENTAL CONSULTATION

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

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.

CONSULTATIONS/VISITS (cont'd)

60E EMERGENCY DEPARTMENT/ADVANCED AMBULATORY CARE CENTRE/URGENT CARE CENTRE VISITS

Payment was refused as:

(a) another physician has claimed for the same service. Submit a new claim with a DSCH modifier in accordance with General Rule 5.1.4 or
(b) HSCs 03.05F, 03.05FA and 03.05FB 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/ADVANCED AMBULATORY CARE CENTRE/URGENT CARE CENTRE VISIT

Payment was refused as the information/diagnostic code provided does not support payment under this HSC. Submit a new claim with the appropriate emergency department/AACC/UCC visit HSC.

GENERAL ASSESSMENT

Explanatory Codes 60EB to 61EA

60EB SERVICES UNSCHEDULED

Payment was refused as the maximum benefit for unscheduled services was reached.

60EC SPECIAL CALLBACKS TO ADVANCED AMBULATORY CARE CENTRE/URGENT CARE CENTRE HOSPITAL EMERGENCY OUT PATIENT DEPARTMENT

Payment was refused according to GR 5.2 in the Schedule of Medical Benefits or GR 17 in the Schedule of Oral and Maxillofacial and Surgery Benefits.

60ED MAXIMUMS FOR SPECIAL CALLBACKS AND SURCHARGES

Your claim was refused or reduced in accordance with the general rules in the applicable benefits schedule.

61 DRESSING CHANGES - BURNS

Your claim for HSC 07.57A and/or 07.57B has been changed to a visit HSC as the service is not for a burn. The corresponding tray service benefit has been deducted where applicable.

61A GENERALIZED DIAGNOSTIC CODES

Payment was refused as this service is included in the benefit paid for the related surgical procedure.

GENERAL ASSESSMENT (cont'd)

61B REMOVAL OF SUTURES

Payment was refused as the benefit for removal of sutures is included in the procedural benefit.

61C NURSING HOME AND SENIOR CITIZENS HOME

Payment was refused as the service was not provided in a "home" location.

61CA AUXILIARY HOSPITAL VISITS

Payment was reduced to a lesser benefit as the service provided was a routine visit for custodial care.

61CB AUXILIARY HOSPITAL/NURSING HOME VISIT/MANAGEMENT OF DIALYSIS PATIENTS

Payment was refused as a visit was paid for a prior date of service during the same calendar week.

61E CONCURRENT CARE

Payment was reduced or refused as services for concurrent care require supporting information.

61EA CONTINUING CARE

Payment was reduced or refused in accordance with the applicable benefits schedule.

Explanatory Codes 61F to 63AA

61F CONFLICTING HOSPITAL DATES

Payment was reduced or refused as a benefit for some or all of the hospital dates of service was previously paid.

61G POST-PARTUM OFFICE VISITS

Payment was refused as this service is not payable when provided to a healthy newborn during the post-partum period.

61H INCLUSIVE - SURGICAL BENEFIT - PRE/POST-OPERATIVE CARE

Payment was refused as pre- and/or post-operative care is included in the procedural benefit.

62 PROFESSIONAL INTERVIEW/CASE CONFERENCE

Payment was refused as HSC 03.05YM may only be claimed when 03.05Y has been previously submitted and paid.

GENERAL ASSESSMENT (cont'd)

63 CLAIM IN PROCESS

Your claim is being held as:

(a) it requires manual assessment or
(b) the supporting information must be reviewed.

DO NOT SUBMIT A NEW CLAIM, as notification of payment or refusal will appear on a future Statement of Assessment.

63A SCHEDULE OF BENEFITS

Payment for your claim was reduced or refused in accordance with the applicable benefits schedule. To view the benefits schedules, go to the Alberta Health website at https://www.alberta.ca/health-wellness.aspx.

63AA UNSCHEDULED SERVICES & DESIGNATED HOLIDAYS

Payment was reduced or refused according to the applicable benefits schedule.

63AC Pandemic Telephone Advice

This claim was refused in accordance with the notes following HSC 03.01AD.

Explanatory Codes 63B to 64AB

63B MAXIMUM NUMBER OF CALLS

Payment was reduced as the maximum number of calls for the HSC was reached.

63C INCLUSIVE HEALTH SERVICE CODE

Payment was refused as there is an inclusive HSC for these services.

64 SUPPORTING INFORMATION

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

64AA UNANSWERED CORRESPONDENCE/TELEPHONE RESPONSE

Payment was refused as our requests for additional information were not answered.

64AB RELATIONSHIP

Payment was refused as the relationship of the relative being interviewed was not provided.

GENERAL ASSESSMENT (cont'd)

Explanatory Codes 64C to 65A

64C INFORMATION PROVIDED

The information provided has been reviewed and payment was:

(a) reduced or refused or
(b) unchanged or
(c) altered.

Future claims of this nature should be submitted under the applicable HSC. HSCs under the 99.09 series (Unlisted Procedures) are to be claimed only for unlisted procedures.

64D ANESTHETIC AND SURGERY DISCREPANCY

Payment was refused as there is a discrepancy between the HSCs submitted on the anesthetic and the surgery claims.

64E DATE CONFLICT

Payment was refused as the date of service does not agree with the anesthetist's, surgical assistant's or surgeon's claim, as applicable.

65 NON-INVASIVE DIAGNOSTIC PROCEDURES IN HOSPITAL/ADVANCED AMBULATORY CARE CENTRE/URGENT CARE CENTRE

Benefits for non-invasive diagnostic procedures including laboratory and pathology and diagnostic radiology services performed for a hospital inpatient, registered outpatient, AACC or UCC patient are not payable under the AHCIP. Payment for these services is the responsibility of the hospital/RHA. This applies to both the technical and professional components.

65A BLOOD SPECIMEN

This claim was refused as payment cannot be made:

(a) for both obtaining a blood specimen and a laboratory test requiring blood or
(b) for services performed by non-laboratory facilities.

Explanatory Codes 65AA to 66

65AA MISCELLANEOUS LABORATORY PROCEDURES

Payment was refused as:

(a) claims submitted for HSC E1 and/or combination of E2, E3, E4, E5 and E7 for the same date of service are not payable in excess of the benefit

GENERAL ASSESSMENT (cont'd)

for E1 or
(b) the greater benefit is paid when claims are submitted for E1 and E41 or E400 for the same date of service or
(c) the greater benefit is paid when claims are submitted for E234 and E235 for the same date of service or
(d) a maximum of either one E553 and one E554 or two E553s or two E554s are paid within a 14 day period.

65D ALLERGY INVESTIGATIONS

Payment was reduced or refused as the maximum benefit for the 365 day period was reached.

65E DETENTION TIME

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

Payment was reduced or refused as:

(a) when a consultation or visit is claimed in association with HSC 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 or
(b) the greater benefit is paid when 03.05A or 13.99J are claimed for the same patient encounter.

Explanatory Codes 66A to 67AB

66A VENTILATORY SUPPORT

Payment was reduced or refused as:

(a) ventilatory support is payable only once every 24 hour period regardless of the number of physicians providing care or
(b) ventilatory support is not payable for the same date of service to the same physician who was paid for either an anesthetic or surgical procedure or
(c) ventilatory support is not payable unless provided in approved level 2 and 3 intensive care and neonatal intensive care units.

67 MULTIPLE CHARGES/SAME ENCOUNTER

Payment was refused as claims for multiple services provided in the same encounter require supporting information.

GENERAL ASSESSMENT (cont'd)

67A PREVIOUS PAYMENT

Payment for this service was refused as:

(a) the claim was previously paid or
(b) the claim was applied at "0" on a previous Statement of Assessment or
(c) the claim was previously paid under a different HSC for the same service under another benefits schedule.

NOTE: 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). Hospital reciprocal claims are an exception and must be resubmitted as described in the Alberta Health and Wellness Hospital Reciprocal Claim Submission Guide.

67AA PAYMENT TO ACCOUNT HOLDER/PATIENT

Payment was refused as the benefit for this service was paid to the account holder/patient.

67AB PREVIOUS PAYMENT - DIFFERENT HEALTH SERVICE CODE

Payment was refused as a benefit was paid under a different HSC.

Explanatory Codes 67AC to 69

67AC PREVIOUS PAYMENT

Payment was refused as this benefit was paid to another practitioner.

67AD DUPLICATE - DIFFERENT SERVICE DATE

Payment was refused as this claim appears to be a duplicate of a previously 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

Payment for this service was refused as:

a) the ward rate was previously paid or
b) the ICU rate was previously paid.

67B LOCATION OF SERVICE CONFLICT

Payment was refused as claims were paid for services that the patient received on this date at a different location/hospital. Verify the dates and resubmit applicable claims with additional details.

GENERAL ASSESSMENT (cont'd)

68A PAYMENT REDUCED

Payment was reduced as the maximum number of claims was reached.

68B PAYMENT REDUCED

Payment was reduced to partial Fee-For-Service as per contract agreement.

68C PAYMENT REDUCED

Payment was reduced to zero as partial Fee-For-Service maximum was reached.

69 ALTERNATE PAYMENT PLAN ADDITIONAL FEE FOR SERVICE PAYMENTS

An additional FFS payment was paid due to additional supporting documentation for special circumstances.

DENTAL ASSESSMENT

70 PRE/POST-OPERATIVE CARE

This claim was assessed in accordance with the general rules in the applicable benefits schedule.

70A TWO DENTAL PROCEDURES

Payment was reduced to 75% of the listed benefit as the major surgical procedure was paid at the full rate.

70D INELIGIBLE DENTAL SERVICES

Payment was refused as:

(a) tissue conditioning is only payable in conjunction with a denture or reline within five years and no reline or denture was claimed for this period or
(b) tissue conditioning is not payable within three months of a partial or complete denture insertion as it is included in the denture insertion benefit or
(c) only two tissue conditioning benefits are payable for a denture or reline within five years. The maximum benefit has been reached.

70E TOOTH IDENTIFICATION

Payment was refused as:

(a) identification of tooth numbers and/or surfaces is required or
(b) the tooth surface field for this procedure must be blank or
(c) the tooth surface(s) indicated is not valid for the tooth code or
(d) the tooth number indicated is not valid for this procedure.

DENTAL ASSESSMENT (cont'd)

70EA DENTAL EXTRACTION

Payment was refused as our records show this tooth was previously extracted.

70EB TOOTH SURFACE/TOOTH CODE

Payment was refused as the tooth surface or tooth code is invalid.

70F DENTURES/REBASE/RESET

Payment was refused as a benefit was paid for a partial or complete denture within the last five years.

70G RELINE OR REBASE

Payment was refused as benefits were paid for a reline in the past two years.

70J INCLUSION WITHIN THE COMPOSITE BENEFIT

Payment was refused as the service is included in the benefit for the major procedure.

70K INELIGIBLE DENTAL MECHANICS SERVICES

Payment was reduced or refused as:

(a) only one oral examination per day is payable when a corresponding new denture or reline benefit is provided on or after January 1, 2001 and paid by the EHB program or
(b) only one oral examination is payable for each new denture or reline service provided or
(c) an oral examination occurred within 90 days of the denture/reline 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.

70L DENTAL PROCEDURES

Payment was refused as when multiple services are claimed for the same date of service, the following applies:

(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

DENTAL ASSESSMENT (cont'd)

a consultation, regardless of whether the services are performed at different encounters.

ADDITIONAL COMPENSATION IN ACCORDANCE WITH GR 2.6

73 ADDITIONAL COMPENSATION CLAIMS

Payment was refused as claims from non-residents, subscribers and allied health professionals with the exception of podiatric surgeons, do not qualify for additional compensation benefits.

73A ADDITIONAL COMPENSATION COMMITTEE

This claim was paid, reduced or refused as recommended by the Additional Compensation Committee.

73BA INCORRECT ADDITIONAL COMPENSATION CLAIM SUBMISSION

Payment was refused as the claim for additional compensation was submitted incorrectly.

73BB NO PAYMENT BY AHCIP

Payment of the additional compensation portion of the claim was refused as there is no record of an AHCIP payment for this service.

73BC REQUEST FOR ADDITIONAL COMPENSATION

Payment was refused as supporting documentation is required for the additional compensation portion of the claim.

73BD NON-INSURED SERVICE

Payment was refused as this service is not insured by the AHCIP.

73BE CHANGE OF PAYMENT RESPONSIBILITY

This additional compensation claim was paid as an AHCIP benefit.

LIMITS

80 RESIDENCY/GOOD FAITH

Payment was refused as Good Faith claims must be submitted within 30 days of the date of service.

80B EYE EXAMINATIONS

Payment was refused as this is the second claim for this type of eye examination for this patient within the benefit period (July 1 to June 30).

LIMITS (cont'd)

80BA OPTOMETRIC SERVICES

Payment was refused as either a complete vision examination, a partial vision examination or a single diagnostic procedure was paid for the same date of service; or the maximum benefit allowed was reached.

80BD FOLLOW-UP VISIT (HSC B901) TEST REQUIRED

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

80BE MAXIMUM BENEFIT REACHED

Payment was refused as the patient has received the maximum benefit payable for this condition/episode subject to the rules in the Optometric Benefits Regulation sections 12(1), 12(3) and 12(4).

80BF PREVIOUS PAYMENT, SAME DATE OF SERVICE

Payment was refused as:

(a) a benefit was paid under a different HSC or
(b) a benefit was paid to another practitioner or
(c) a benefit was previously paid.

LIMITS (cont'd)

80BH COMPUTER ASSISTED VISUAL FIELDS (B905) - TEXT REQUIRED

Payment was refused as explanatory text was not provided. Subject to the Optometric Benefits Regulation section 13(2), a claim for B905 must be accompanied by explanatory text unless the diagnostic code submitted is Glaucoma (365.0-365.8), Retina Detachments and Defects (361.0-361.3, 361.8) or Disorders of the Optic Nerve and Visual Pathways (377.0-377.7).

80C PODIATRIC/DENTAL LIMITS

This claim has been reduced or refused as:

(a) the yearly limit for podiatric benefits has been reached; however payment may be reviewed at a later date if changes to other related claims for this patient are received or
(b) the calendar year limit for the following dental service(s) has been reached:
-a benefit for only two examinations of any type may be paid in a calendar year or
-a benefit for only two films may be paid in a calendar year or
-a benefit for panoramic x-rays may be paid once every five calendar years or
-a benefit for no more than two units of time (30 minutes) for subgingival scaling/root planing may be paid in a calendar year.

80D EYEGLASSES/LENSES/FRAME

Payment has been reduced or refused as this patient has received:

(a) eyeglasses within the last three years or
(b) lenses/lens within the last three years.

80F TWELVE MONTH LIMIT

Payment has been reduced or refused as the patient has received this benefit within twelve months.

80G OUTDATED CLAIMS

Payment was refused as the time limit for submission has expired.

80H CONTRACT LIMITS

Payment was reduced or refused as the contract limit was reached.

80J PRACTITIONER/BUSINESS ARRANGEMENT LIMITS

Payment was reduced or refused as the limit was reached for the service provider or the BA.

LIMITS (cont'd)

80K RECIPIENT LIMIT HAS BEEN REACHED FOR ALTERNATE PAYMENT PLAN CONTRACT

Payment was refused or reduced as the recipient has reached capitation rate.

80L ALTERNATE PAYMENT PLAN FEE FOR SERVICE

Payment was reduced as the capitation maximum was paid for the month of service.

80M BUSINESS COST PROGRAM

Payment has been reduced or applied at "0" as the cap has been reached.

ADJUSTMENTS

90 PAYMENT REDUCTION

This is an adjustment of a previously assessed item.

90A PREVIOUS CORRESPONDENCE - MUTUAL INFORMATION

This claim has been assessed in accordance with correspondence or telephone call.

90D ADJUSTMENT, RECIPIENT NO LONGER ELIGIBLE FOR COVERAGE

This is an adjustment to update your records only. Payment has not been deducted from your account.

NOTE: The patient is not eligible for AHCIP coverage for the date of service and will be billed by the AHCIP.

90E ADJUSTMENT, RECIPIENT DECEASED

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. 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.

HOSPITAL RECIPROCAL

95 NEWBORN

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

95A INPATIENT/OUTPATIENT SERVICES

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.

HOSPITAL RECIPROCAL (cont'd)

95B DAY OF DISCHARGE

Payment has been reduced as the standard ward rate is not payable for the day of discharge.

95C HIGH COST PROCEDURE/ZERO WARD RATE

Payment was refused as when a high cost procedure and an inpatient standard ward rate are being claimed, two separate claims must be submitted:

(a) one claim showing the admission and discharge date and an inpatient standard ward rate, with the claimed amount of zero, and
(b) the other claim for the high cost procedure.

95D MULTIPLE TRANSPLANTS SAME HOSPITAL STAY

Payment was refused as multiple same organ transplants within the same hospital stay are not payable.

95E REDUCED BENEFITS

Payment has been reduced as the number of days between the admission and discharge dates do not agree with the claimed amount.

95F OUTPATIENT SERVICES

Payment was refused as an outpatient hospital service has been previously paid for this patient for this date of service.

95G MAXIMUM NUMBER OF SERVICES

Payment was refused as the maximum number of services was paid.

95K CLAIM IN PROCESS

Hold for documentation.

95L OUT OF PROVINCE REGISTRATION EXPIRY DATE

Payment was refused as the out of province registration expiry date must be blank if the out of province registration number is blank.

95M UNABLE TO PROCESS UPDATED TRANSACTION

The transaction to update a previously submitted claim cannot be processed as:

(a) the original add transaction cannot be located or
(b) the result of your original claim is unknown, or
(c) the original claim was previously deleted.

Please review your records and resubmit, if applicable.

HOSPITAL RECIPROCAL (cont'd)

95T INVALID ICD10CA DIAGNOSTIC CODE

Payment was refused as the diagnostic code is invalid. Only the International Statistical Classification of Diseases and Related Health Problems, 10th Canadian Revision, diagnostic codes (ICD10CA) are acceptable for hospital reciprocal inpatient billing.

Adjustments Requested by Home Province

96A MOTHER/NEWBORN REGISTRATION NUMBER

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

96B DECLARATION FORM INCOMPLETE/INCORRECT

This is an adjustment of a previously processed claim. Payment was deducted as the Declaration Form requested by the patient's home province was:

(a) not provided or
(b) incomplete or
(c) not signed by the patient or parent/guardian.

96C OUT OF PROVINCE PATIENT INFORMATION/CLAIM INFORMATION DISCREPANCY

This is an adjustment of a previously processed claim. Payment was deducted because there is a discrepancy between:

(a) the home province's patient registration information and the patient information submitted or
(b) the expiry date on the patient's health card and the expiry date submitted.

96D OUT OF PROVINCE PATIENT'S COVERAGE NOT EFFECTIVE

This is an adjustment of a previously processed claim. Payment was deducted as the patient's home province has verified that the patient's health card was not valid on:

(a) the date of service or
(b) the admission date or
(c) the discharge date.

96E INCORRECT CLAIM - ALBERTA RESPONSIBILITY

Our records indicate that the patient was an Alberta resident on the date of service; therefore, this claim has been:

(a) refused or

HOSPITAL RECIPROCAL (cont'd)

(b) adjusted from your previous payment.

96F WORKERS' COMPENSATION BOARD RESPONSIBILITY

This is an adjustment of a previously processed claim. Payment was deducted as we have received information advising this service is the responsibility of the WCB. This claim should be submitted directly to the WCB.

96G 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 submit a new claim using the correct information, if applicable.

96H SECOND OUTPATIENT VISIT

This is an adjustment of a previously processed claim. Payment was deducted as multiple outpatient visits on the same day for the same patient are not payable.

Note: Charges for additional outpatient visits may not be billed directly to the patient or home province.

Adjustments Requested by Alberta RHA/Hospital

97A 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 submit a new claim using the correct information, if applicable.

ALTERNATE PAYMENT PLAN

98 CAPITATION PAID

Payment was refused as capitation (payment in lieu of FFS benefits) was paid for this patient for this date of service.

ALTERNATE PAYMENT PLAN (cont'd)

98A INVALID HEALTH SERVICE CODE

Payment was refused as this HSC may not be claimed by the BA indicated.

98AA FEE FOR SERVICE/ALTERNATE PAYMENT PLAN REASSESSED CLAIMS

Thank you for your payment. Your FFS claim transactions have been reassessed and applied as APP billing.

Registration

98B NON PATIENT-SPECIFIC UNIQUE LIFETIME IDENTIFIER - OTHER INTERVENTIONS

This transaction was refused as the non patient-specific ULI must be used for services defined as other interventions.

Practitioner Registration

98C LOCUM BUSINESS ARRANGEMENT - FEE FOR SERVICE

This transaction was refused as a practitioner with a locum BA may not be paid FFS under an APP practice.

Ineligible Services

98D OTHER INTERVENTIONS - NON-ENROLLED PATIENTS

This transaction was refused as services defined as other interventions may not be submitted for non-enrolled patients.

98DA OTHER INTERVENTIONS NOT ELIGIBLE UNDER GOOD FAITH

This transaction was refused as services defined as other interventions may not be claimed under the Good Faith program.

98DB INELIGIBLE OTHER INTERVENTIONS

This transaction was refused as this other intervention service may not be claimed under this APP program.

98DC DATE OF SERVICE/ALTERNATE PAYMENT PLAN EFFECTIVE DATE

This transaction was refused as the APP program is not active for this date of service.

Incomplete Claims / Additional Information Required

98E INVALID PAY-TO CODE

This transaction was refused as the pay-to code must be "BAPY" (BA Payee) for all APP services.

ALTERNATE PAYMENT PLAN (cont'd)

98EA INVALID HEALTH SERVICE CODE - NON PATIENT-SPECIFIC UNIQUE LIFETIME IDENTIFIER

This transaction was refused as only HSCs that are defined as non patient-specific may be submitted under the non patient-specific ULI.

98EB INVALID BUSINESS ARRANGEMENT NUMBER

This transaction was refused as the APP BA number must be used for all services listed as other interventions.