SCAN HEALTH PLAN

Standard Companion Guide Transaction Information
Instructions are related to the SCAN Proprietary Prior Authorization Electronic Data Transaction. This transaction includes details related to the ASC X12 Technical Report Type 3 (TR3), Version 005010X217 as well as detail pertaining CMS Organizational Determinations.

Companion Guide Version Number: 1.4
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Preface

This Companion Guide contains information to assist SCAN's Trading Partners in the acceptance and processing of prior authorization data. The SCAN Companion Guide is under development and the information in this version reflects current decisions and will be modified on a regular basis. All versions of the SCAN Companion Guide are identified by a version number which is located in the version control log on the last page of the document. Users should verify they are using the most current.

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1 Introduction

1.1 Scope

The SCAN Prior Authorization Companion Guide details how Trading Partners should submit authorization data to SCAN.

1.2 Overview

The information is organized in the sections listed below:

- Contacts and Resources: This section includes telephone numbers and email addresses for SCAN as well as applicable website resources.
- Required Authorization Data: This section includes fields required by SCAN.
- Business Rules: this section includes business rules associated with the authorization data.
- Version control Log: This section contains the revision history of the document.

1.3 Definition of key terms

Term	Definition
SCAN	SCAN Health Plan (MAO)
CMS	Centers for Medicare and Medicaid Services
ODAG	Organizational Determinations – Grievances and Appeals
ODR	Organizational Determinations - Reopening
EDI	Electronic Data Interchange

1.4 Resources

Resource	Website
ANSI ASC X12 TR3 Implementation Guides	http://www.wpc-edi.com/
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/
CMS ODR and ODAG Audit Regulations	https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin.html

2 Purpose

Prior Authorization data send to SCAN by Provider groups is expected to contain inpatient and outpatient authorizations, though all authorization types may be sent. Although SCAN's Medical Management may receive notification of a patient stay directly from the facility, the Provider authorization entered by the group will be used as the source of truth at SCAN. Therefore it is imperative that SCAN's Provider Partners submit their authorizations to SCAN regularly and in a timely fashion.

Authorization data obtained by SCAN will be used for a multitude of purposes which include, but are not limited to: claims processing/payment and CMS Organizational Determination Audits.

3 Contacts

3.1 SCAN Contacts

Technical Contact Information			
Name	**Title**	**Contact Phone**	**Contact Email**
Char Beecher	Manager, EDI	562-308-1126	cbeecher@scanhealthplan.com
AJ Bautista	EDI Analyst, Sr.	562-637-1297	ajbautista@scanhealthplan.com
EDI Inbox	EDI Notifications		EDINotifications@scanhealthplan.com

Business Related Contact Information			
Name	**Title**	**Contact Phone**	**Contact Email**
Chavette Watts	Medical Mgmt Quality Specialist	562-997-1588	CWatts@scanhealthplan.com
Nathan Norbryhn	Director of Performance Management	562-989-4438	NNorbryhn@scanhealthplan.com

4 File Instructions

File Format Notes
1. File format must be followed as defined on the Complete File Format Tab
2. Files are to be Pipe (|) delimited.
3. All fields must be included in each record. If the field is optional or situational and there is no data to populate the field, then leave the field blank, but the field must be present in the file.
4. Column headings should not be included in the data file.

Usage Legend		
R	**Required**	Data must always appear in field
S	**Situational**	Data may or may not be required in field

File Naming Convention
DA_C_<SubmitterID>_<MedicalGroupName>_<YYYYMMDD>.<ext> **where:** SubmitterID = SCAN assigned ID for delegated auth submission MedicalGroupName = the SCAN providerpartner name YYYYMMDD = the date the file is being submitted Ext = filetype must be .txt **Naming Convention Rules:** The filename should NOT have any spaces in it Please use only lowercase letters in the filename

4.1 Data Fields and Notes

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Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
1	Submitter ID	Authorizing Network/Group Submitter ID	R	1	10		Assigned by SCAN
2	Authorization Type	Place of Service	R	2	2		See Place of Service Codes list for qualifiers. **Table 7.1.1**
3	Requesting Provider NPI	NPI of Provider that is requesting the authorization	S	10	10	Required unless Provider does not have an NPI, then license/name required	
4	Requesting Provider License #	License # of Provider that is requesting the authorization	S	1	20	Only required if Provider does not have an NPI	
5	Requesting Provider Last Name	Last Name or Entity name of Provider that is requesting the authorization	S	1	60	Only required if Provider does not have an NPI	
6	Requesting Provider First Name	First name of Provider that is requesting the authorization	S	1	35	Only required if Provider does not have an NPI	
7	Servicing Provider NPI	Provider that is performing the authorized services	S	10	10	Required unless Provider does not have an NPI, then license/name required	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
8	Servicing Provider License #	License # of Provider that is performing the authorization	S	1	20	Only required if Provider does not have an NPI	
9	Servicing Provider Last Name	Last Name or Entity name of Provider that is performing the authorization	S	1	60	Only required if Provider does not have an NPI	
10	Servicing Provider First Name	First name of Provider that is performing the authorization	S	1	35	Only required if Provider does not have an NPI	
11	Network Flag	Used to determine if requesting provider is Out of Area or Out of Network	S	2	2	(OA = out of area, ON = out of network)	Populate if known and available.
12	SCAN Member Last Name		R	1	60		
13	SCAN Member First Name		R	1	35		
14	SCAN Member Middle Initial		S	1	1		
15	SCAN Member ID		R	11	11		
16	SCAN Member DOB		R	8	8	Format: MMDDCCYY	
17	Request Category Code	Indicator for authorization pre-service or post service	R	1	2	**PR** = pre-service authorization, **CO**=concurrent authorization, **RP**=retrospective authorization	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
18	Request Type Code	Type of authorization	S	1	1	**1**=Appeal **4**=extension **I**=initial **R**=renewal, **S**=revision	Required when updating an already accepted authorization.
19	Authorization Number	Reviewing entities authorization number	R	1	50		Preferred that Auth numbers are no longer than 15 characters, but can accepted 1-50.
20	ICD Classification	flag to indicate if DX codes are ICD9 or ICD10	R	1	2	9=ICD9, 10=ICD10	
21	Primary Diagnosis Code		R	3	8	**At least one DX code is required**	Do not include decimal
22	Diagnosis Code2		S	3	8	if applicable	Do not include decimal
23	Diagnosis Code3		S	3	8	if applicable	Do not include decimal
24	Diagnosis Code4		S	3	8	if applicable	Do not include decimal
25	Diagnosis Code5		S	3	8	if applicable	Do not include decimal
26	Diagnosis Code6		S	3	8	if applicable	Do not include decimal
27	Diagnosis Code7		S	3	8	if applicable	Do not include decimal
28	Diagnosis Code8		S	3	8	if applicable	Do not include decimal
29	Diagnosis Code9		S	3	8	if applicable	Do not include decimal
30	Diagnosis Code10		S	3	8	if applicable	Do not include decimal
31	Diagnosis Code11		S	3	8	if applicable	Do not include decimal
32	Diagnosis Code12		S	3	8	if applicable	Do not include decimal
33	Authorization Certification DateTime	Date authorization was certified (aka - decision date)	S	12	12	Format: MMDDCCYYHHMM	Required if not reported for each service line

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
34	Certification Action Code	Authorization certification status (aka - decision or reason code)	S	1	3	Required if not reported for each service line level.	See Certification Action Code list for acceptable codes. **Table 7.1.2**
35	Start Date of Service	Start Date of Service Authorization was for	S	8	8	Format: MMDDCCYY	Start Date of Service and/or Authorization Start Date must be present
36	End Date of Service	End Date of Service Authorization was for	S	8	8	Format: MMDDCCYY	End Date of Service and/or Authorization Expiration Date must be present
37	Authorization Start Date	Start of Authorization time period	S	8	8	Format: MMDDCCYY	Authorization Start Date and/or Start Date of Service must be present
38	Authorization Expiration Date	End of Authorization time period	S	8	8	Format: MMDDCCYY	Authorization Expiration Date and/or End Date of Service must be present
39	Total Units Requested		S	1	15	Authorizations Request for number of units	Total units on authorization if applicable
40	Total Days Requested		R	1	15	Authorizations Request for number of days	Total days on authorization
41	Total Visits Requested		S	1	15	Authorizations Request for number of visits	Total visits on authorization if applicable
42	Free-Form Authorization Notes		S	1	264		
43	Admission Date Time Period	For Inpatient authorization, admission date	S	8	8	Format: MMDDCCYY	Only required for inpatient authorizations

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
44	Discharge Date Time Period	For Inpatient authorization, discharge date	S	8	8	Format: MMDDCCYY	Only required for inpatient authorizations
45	Admission Type Code	For inpatient authorizations	S	1	1		See Admission Type Codes list for acceptable codes. **Table 7.1.3**
46	Admission Source Code	For inpatient authorizations	S	1	1		See Admission Source Code List for acceptable codes. **Table 7.1.4**
47	Patient Status Code	For inpatient authorizations	S	1	2		See Patient Status Code List for acceptable codes. **Table 7.1.5**
48	Requestor Type Code	Type of entity requesting the authorization	S	3	3		See Requestor Type Code List for acceptable codes. **Table 7.1.8**
49	AOR or WOL Received DateTime	Appointment of Representative OR Waiver of Liability form received date.	S	12	12	Format: MMDDCCYYHHMM	
50	Auth Requested DateTime	Date and time the auth was requested by provider/beneficiary.	S	12	12	Format: MMDDCCYYHHMM	
51	Auth Entered/Effectuated DateTime	Date and time the auth was entered/effectuated in the sponsor's system.	S	12	12	Format: MMDDCCYYHHMM	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
52	Extension Taken	Was a timeframe extension taken? (Y/N)	S	1	1		
53	Expedited Grievance Notification	If an extension was taken, was the member notified of their right to file an expedited grievance? (Y/N)	S	1	1	Required if an extension was taken.	
54	Denied and reviewed for medical necessity?	If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional? (Y/N)	S	1	1		
55	Verbal Notification DateTime	Date oral notification provided to enrollee.	S	12	12	Format: MMDDCCYYHHMM	
56	Written Notification DateTime	Date written notification provided to enrollee.	S	12	12	Format: MMDDCCYYHHMM	The term “provided” means when the letter left the sponsor’s establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor’s organization.
57	Dismissal DateTime	Date authorization was dismissed, if applicable.	S	12	12	Format: MMDDCCYYHHMM	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
58	Reopening Reason Code	Reason for reopening. Only populate for re-opened authorization requests.	S	2	2		See Reopening Reason Code List for acceptable codes. **Table 7.1.9**
59	Reopening Certification Action Code	Reopened Authorization certification status (aka - decision or reason code)	S	2	3		See Certification Action Codes List for acceptable codes. **Table 7.1.2**
60	Subsequent Expedited Requestor	Identifies the requestor when a request originated as standard but was upgraded to expedited.	S	1	3		See Requestor Type Codes Code List for acceptable codes. **Table 7.1.8**
61	Was Request Processed as Expedited?	Indicates if the request was processed as expedited.	R	1	1	Format: Y/N	
	Service Line 1	**First service line being authorized**					
62	HCPCS or CPT Procedure Code		S	3	7	Required if REV code not being reported	
63	Procedure Code Modifier1		S	2	2	If applicable	
64	Procedure Code Modifier2		S	2	2	If applicable	
65	Procedure Code Modifier3		S	2	2	If applicable	
66	Procedure Code Modifier4		S	2	2	If applicable	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
67	REV Code		S	3	4	Required for inpatient authorizations when HCPCS/CPT code not populated	Submit REV codes with leading zeros if applicable
68	Start Date of Service		S	8	8	Format: MMDDCCYY	
69	End Date of Service		S	8	8	Format: MMDDCCYY	
70	Procedure Amount	Estimated dollar amount of service line	S	1	18	Include decimal point; Do not include dollar sign.	
71	Procedure Units Qualifier		S	2	2	MJ=minutes, UN=units. Required if Procedure Units being reported	
72	Procedure Units		S	1	15		
73	Authorization Certification DateTime	Date service line authorization was certified (aka - decision date and time)	S	12	12	Format: MMDDCCYYHHMM Required if not reported at Auth level.	
74	Certification Action Code	Service Line Authorization certification status (aka - decision/reason code)	S	1	3	Required if not reported at Auth level.	See Certification Action Code list for acceptable codes. **Table 7.1.2**
	Service Line 2	**Second service line being authorized**					
75	HCPCS or CPT Procedure Code		S	3	7	Required if REV code not being reported	
76	Procedure Code Modifier1		S	2	2	If applicable	
77	Procedure Code Modifier2		S	2	2	If applicable	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
78	Procedure Code Modifier3		S	2	2	If applicable	
79	Procedure Code Modifier4		S	2	2	If applicable	
80	REV Code		S	3	4	Required for inpatient authorizations when HCPCS/CPT code not populated	Submit REV codes with leading zeros if applicable
81	Begin Date of Service		S	8	8	Format: MMDDCCYY.	
82	End Date of Service		S	8	8	Format: MMDDCCYY	
83	Procedure Amount	Estimated dollar amount of service line	S	1	18	Include decimal point; Do not include dollar sign.	
84	Procedure Units Qualifier		S	2	2	MJ=minutes, UN=units. Required if Procedure Units being reported	
85	Procedure Units		S	1	15		
86	Authorization Certification DateTime	Date service line authorization was certified (aka - decision date and time)	S	12	12	Format: MMDDCCYYHHMM Required if not reported at Auth level.	
87	Certification Action Code	Service Line Authorization certification status (aka - decision or reason code)	S	1	3	Required if not reported at Auth level.	See Certification Action Code list for acceptable codes. **Table 7.1.2**
	Service Line 3	**Third service line being authorized**					

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
88	HCPCS or CPT Procedure Code		S	3	7	Required if REV code not being reported	
89	Procedure Code Modifier1		S	2	2	If applicable	
90	Procedure Code Modifier2		S	2	2	If applicable	
91	Procedure Code Modifier3		S	2	2	If applicable	
92	Procedure Code Modifier4		S	2	2	If applicable	
93	REV Code		S	3	4	Required for inpatient authorizations when HCPCS/CPT code not populated	Submit REV codes with leading zeros if applicable.
94	Begin Date of Service		S	8	8	Format: MMDDCCYY	
95	End Date of Service		S	8	8	Format: MMDDCCYY	
96	Procedure Amount	Estimated dollar amount of service line	S	1	18	Include decimal point; Do not include dollar sign.	
97	Procedure Units Qualifier		S	2	2	MJ=minutes, UN=units. Required if Procedure Units being reported	
98	Procedure Units		S	1	15		
99	Authorization Certification DateTime	Date service line authorization was certified (aka - decision date and time)	S	12	12	Format: MMDDCCYYHHMM Required if not reported at Auth level.	

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
100	Certification Action Code	Service Line Authorization certification status (aka - decision or reason code)	S	1	3	Required if not reported at Auth level.	See Certification Action Code list for acceptable codes. **Table 7.1.2**
	Service Line 4	**Fourth service line being authorized**					
101	HCPCS or CPT Procedure Code		S	3	7	Required if REV code not being reported	
102	Procedure Code Modifier1		S	2	2	If applicable	
103	Procedure Code Modifier2		S	2	2	If applicable	
104	Procedure Code Modifier3		S	2	2	If applicable	
105	Procedure Code Modifier4		S	2	2	If applicable	
106	REV Code		S	3	4	Required for inpatient authorizations when HCPCS/CPT code not populated	Submit REV codes with leading zeros if applicable.
107	Begin Date of Service		S	8	8	Format: MMDDCCYY	
108	End Date of Service		S	8	8	Format: MMDDCCYY	
109	Procedure Amount	Estimated dollar amount of service line	S	1	18	Include decimal point; Do not include dollar sign.	
110	Procedure Units Qualifier		S	2	2	MJ=minutes, UN=units. Required if Procedure Units being reported	
111	Procedure Units		S	1	15		

Sequence	Field Name	Description	Usage	Min Len	Max Len	Rule	Notes
112	Authorization Certification DateTime	Date service line authorization was certified (aka - decision date and time)	S	12	12	Format: MMDDCCYYHHMM Required if not reported at Auth level.	
113	Certification Action Code	Service Line Authorization certification status (aka - decision or reason code)	S	1	3	Required if not reported at Auth level.	See Certification Action Code list for acceptable codes. **Table 7.1.2**

5 Claim and Authorization Matching

The information received from authorizations is used by the SCAN claim system to match and streamline the claim payment process. The set of data elements required to match an authorization to a claim differs based on service type and claim type; this relationship is outlined in the table below (**Table 5.1**). Please ensure authorizations sent to SCAN contain all required data elements per the data fields and notes section of this document (**Table 4.1**).

5.1 Data Elements Necessary for Matching

Service Type	Claim Type	Provider IDs	Member IDs	Admit/Discharge Date	Service Location	Begin/End Date Range	Service Code	Units
Inpatient	UB-92	X	X	X				
Inpatient	HCFA-1500	X	X	X	X			
Observation	UB-92	X	X		X	X		
Observation	HCFA-1500	X	X		X	X		
Outpatient	UB-92	X	X			X	X	X
Outpatient	HCFA-1500	X	X		X	X	X	X
Other (Referral)	UB-92	X	X			X	X	X
Other (Referral)	HCFA-1500	X	X		X		X	X
Other Provider	HCFA-1500	X	X		X	X	X	X

6 Delegated Authorization Rejections

6.1 Rejections Overview

6.1.1 Delegated Authorization Rejection Reports are provided by SCAN on a monthly basis via SFTP. These reports contain front-end and business rule rejections and include the pertinent information to assist in correcting the errors.

6.2 Common Authorization Errors - Prevention and Remediation

Below are the top rejection reason codes/descriptions from 2018, along with corrective guidance:

Reason Code	Reason Description
DA0008	Member ID invalid during eligibility timeframe

Possible Causes	Preventative Measures/Solutions
• SCAN MemberID is missing • Member ID invalid during eligibility timeframe	• SCAN Member ID is included in the authorization • Include a Member ID that is valid during the date of service timeframe

Reason Code	Reason Description
DA0014	Primary Diagnosis Code required

Possible Causes	Preventative Measures/Solutions
• The primary diagnosis code is missing	• Ensure that the **Primary Diagnosis Code** field is always populated.

Reason Code	Reason Description
DA0015	Primary diagnosis code invalid

Possible Causes	Preventative Measures/Solutions
• The primary diagnosis code is not a valid code • The primary diagnosis code is an expired code	• Verify that the code actually exists • Make sure the code is valid for the dates of service

Reason Code	Reason Description
DA0027	Authorization Certification Date invalid. Must be in MMDDCCYY format with no separators. Must be present at authorization level OR service line level. Both cannot be blank.

Possible Causes	Preventative Measures/Solutions
• Missing/Invalid Authorization Certification Date at authorization level or service line level • Dates not in MMDDCCYY format (no separators)	• Confirm that the Authorization Certification Date is populated at the authorization level or service line level • Ensure the date is populated in the MMDDCCYY format

Reason Code	Reason Description
DA0028	Certification Action Code is Invalid. Code must be present at authorization level OR service line level. Both cannot be blank

Possible Causes	Preventative Measures/Solutions
• Missing/Invalid Certification Action Code at Authorization or Service Line level	• Certification Action Code must be present • Include a valid Certification Action Code at Authorization or Service Line level

Reason Code	Reason Description	
DA0041	Invalid Service Line Procedure Code	
Possible Causes		**Preventative Measures/Solutions**
• A service level procedure code is missing • A service level procedure code is not a valid code • A service level procedure code is an expired code		• Ensure that the service line's **Procedure Code (HCPCS or CPT)** field is populated. • Procedure code must be present when revenue code is not reported. • Procedure Code must be present when service line detail is being submitted without a REV Code. • Make sure the code is valid for the dates of service requested. • Verify that the code exists in ICD-10

Reason Code	Reason Description	
DA0042	Invalid Service Line Revenue Code	
Possible Causes		**Preventative Measures/Solutions**
• A service level revenue code is missing • A service level revenue code is not valid code • A service level revenue code is an expired code		• Ensure that the service line's **REV Code** field is populated for **all inpatient** authorizations where service line detail is being submitted. • Verify that the code exists in ICD-10 • Make sure the code is valid for dates of service requested.

Reason Code	Reason Description	
DA0047	Servicing Provider NPI is required for authorizations with a professional or specialty Authorization Type	
Possible Causes		**Preventative Measures/Solutions**
• Missing/Invalid Servicing Provider NPI		• Ensure that the Servicing Provider field is populated with a valid NPI Serving Provider NPI must be present • Note: NPI must belong to an Organization Entity when the place of service is inpatient or outpatient, and individual's NPI cannot be sent. The facility's Organizational NPI must be sent.

Reason Code	Reason Description	
DA0050	Date of service cannot be determined. At least one of the following sets of dates must be present and valid: Start DOS + End DOS, or Admission Date Time + Discharge Date Time, or Authorization Start Date + Authorization Expiration Date. All dates must be in MMDDCCYY format with no separators	
Possible Causes		**Preventative Measures/Solutions**
• Missing/Invalid Start DOS + End DOS • Missing/Invalid Admission Date Time + Discharge Date Time • Missing/Invalid Authorization Start Date + Authorization Expiration Date • Dates not in MMDDCCYY format (no separators)		• Include at least one of the following valid sets of dates: ○ Start DOS + End DOS ○ Admission Date Time + Discharge Date Time ○ Authorization Start Date + Authorization Expiration Date ○ All dates must be in MMDDCCYY format (no separators)

Reason Code	Reason Description
DA0051	Requesting Provider NPI belongs to an individual entity. When the POS is a hospital, the NPI must belong to an organization

Possible Causes	Preventative Measures/Solutions
• Requesting Provider NPI populated belongs to an individual	• Verify populated Requesting NPI belongs to an organization • Ensure the POS is correct • NPI must belong to an Organization Entity when the place of service is inpatient or outpatient, and individual's NPI cannot be sent. The facility's Organizational NPI must be sent.

Reason Code	Reason Description
DA0052	Start DOS not valid

Possible Causes	Preventative Measures/Solutions
• Start DOS does not align with Admission Date/Authorization Start Date	• Authorization Start and Expiration Dates must always be equal to or greater than other date sets • Authorization Start Date ≤ Start Date of Service • Authorization Start Date ≤ Admission Date • Admission Date ≤ Start DOS

Reason Code	Reason Description	
DA0053	End DOS not valid	
Possible Causes		**Preventative Measures/Solutions**
• End DOS does not align with Discharge Date/Authorization End Date		• Authorization Start and Expiration Dates must always be equal to or greater than other date sets • Authorization End Date ≥ End Date of Service • Authorization End Date ≥ Discharge Date • Discharge Date ≥ End DOS

Reason Code	Reason Description	
DA0054	Authorization_Start_Date after Admission Date	
Possible Causes		**Preventative Measures/Solutions**
• Authorization Start Date reported as taking place after Admission Date		• Authorization Start and Expiration Dates must always be equal to or greater than other date sets • Authorization Start Date ≤ Admission Date

6.3 Use Case Scenarios

6.3.1 There are several different situations where an authorization needs to be requested/opened a second time. Per CMS, a **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record. **Please use original authorization number when submitting a reopened authorization.** This section goes over how to categorize reopened authorizations, using the request category code field:

Request Type Code	Request Type Code Description	Use Case(s)
1	Appeal	Use this code if an authorization was originally denied, then later re-requested and approved.
4	Extension	Use this code if an authorization's service date/time period has already begun, but needs to be extended past the originally requested date/time.
R	Renewal	Use this code if an authorization's services are meant to be performed on a recurring basis, AND one or more occurrence has already taken place on a previous date. **Ex:** Quarterly injections, dialysis, etc.
S	Revision	Use this code if an authorization has had any changes in requested services. **Ex:** Changes in procedure, diagnosis, quantity of services, etc.
Note: **When submitting a reopened authorization, please ensure to use the original authorization number**		

6.3.2 This section reviews how and when to use the "Subsequent Expedited Requestor" field:

Field Name	Use Case(s)
Subsequent Expedited Requestor	Identifies the requestor when a request originated as standard but was upgraded to expedited. This field is to be populated with one of the requestor type codes listed in the Requestor Type Codes table. **Ex:** Upon receipt, request is evaluated by a clinical reviewer who determines request meets criteria for expedited review based on medical necessity.

6.3.3 This section goes over when to utilize the "Sponsor" requestor type code in authorizations:

Requestor Type Code	Requestor Type Code Description	Use Case(s)
S	Sponsor	Use this code when the delegate making the organization determination is the sponsor. **Ex:** Used when the delegate reviews and makes a determination.

6.3.4 This section examines when to utilize the “Other,” “Fraud or Similar Fault,” and “Other Error” reopening Reason Codes in authorizations:

Reopening Reason Codes	Reopening Reason Description	Use Case(s)
OT	Other	Use when non-clerical errors arise due to change in policy, procedure, business configuration, provider update, other adjustments. **Ex:** Claims submitted for multi-group specialty require tax ID of group beginning on X date, original submitted under individual provider ID.
FS	Fraud or Similar Fault	To be used when a request is identified to have been knowingly paid incorrectly, and/or when a wide discrepancy exists between new data and data initially submitted, changed event is material (i.e. will change payment and create a new overpayment of enlarge an existing payment). **Ex:** Initial submitted claim for a provider that did not provide the service.
OE	Other Error	Use when there is an error that is not any of the following: a clerical error (mathematical, computational, inaccurate coding, computer error), new or material evidence, fraud or similar fault. **Ex:** Professional courtesy.

7 Appendices

7.1 Code Tables

7.1.1

Place of Service Codes	
Code	**Service Location Description (Ika)**
11	Office
12	Patient's Home
13	Assisted Living Facility
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance Land
42	Ambulance Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hosp
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comp Outpatient Rehab Facility
65	End-Stage Renal Disease Treatment Center
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

7.1.2

Certification Action Codes	
Code	**Certification Action Description**
AP	Delegated Approval
D0	Benefit Exhausted
D1	Level of Care Not Appropriate
D2	Member Not Eligible
D3	Not a Covered Benefit
D4	Does Not Meet Criteria
D5	Out of Network Provider
D6	Does not meet medical necessity
D9	Other Health Insurance
D17	Opt-Out/Excluded Provider
PN	Delegated Auth, Invalid decision reason
A15	Modified/Partial - Modified Partially Favorable
V16	Dismissal
WI	Withdrawn

7.1.3

Admission Types Codes	
Code	**Description**
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information Not Available

7.1.4

Admission Source Codes	
Code	**Description**
1	Non-Health Care Facility Point of Origin (Physician Referral)
2	Clinic
3	HMO Referral - Physician
4	Transfer from a Hospital (Different Facility)
5	Transfer from a SNF or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Emergency Room (ER)
8	Court/Law Enforcement
9	Information Not Available

7.1.5

Patient Status Codes	
Code	**Description**
01	Routine Discharge
02	Discharged to another short-term general hospital
03	Discharged to SNF
04	Discharged to ICF
05	Discharged to another type of institution
06	Discharged to care of home health service organization
07	Left against medical advice
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)
20	Expired or did not recover
30	Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)
40	Expired at home (hospice use only)
41	Expired in a medical facility (hospice use only)
42	Expired—place unknown (hospice use only)
43	Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital)
50	Hospice—Home
51	Hospice—Medical Facility
61	Discharged/ Transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)
64	Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)

7.1.6

Request Category Codes	
Code	**Request Category Description**
EX	Expedited preservice authorization
PR	Standard preservice authorization
CO	Concurrent authorization
RP	Retrospective authorization

7.1.7

Request Type Codes	
Code	**Request Type Description**
1	Appeal
4	Extension
I	Initial
R	Renewal
S	Revision

7.1.8

Requestor Type Code	
Code	**Requestor Description**
CP	Contracted Provider
NCP	Non-Contracted Provider
B	Beneficiary
BR	Beneficiary representative
S	Sponsor

7.1.9

Reopening Reason Codes	
Code	**Reopening Reason Description**
EE	Clerical Error
NE	New/Material Evidence
OT	Other
FS	Fraud or Similar Fault
OE	Other Error

7.2 Business Rules

7.2.1 File frequency (daily, weekly, monthly, etc.) is mutually agreed upon at time of implementation.

7.2.2 File Naming Convention: <DA>_<C>_<SubmitterID>_<MedicalGroupName>_<DateStamp>.<ext>
Example: DA_C_MG001234_MedicalGroupName_20180402

7.2.4 Files are delivered (or picked up by Vendor) via SFTP (secure file transfer protocol).

7.3 Version Control Log

Version	Version or Change Explanation	By	Date
1.0	Initial Draft	Esteban Stelpflug Char Beecher	6/13/2017
1.1	Authorization-Claim Match Method and Sources Added	Esteban Stelpflug	10/12/2017
1.2	Added Authorization Rejection Resolutions and Use Case Scenarios	Esteban Stelpflug	10/27/2017
1.3	Added Additional Use Case Scenarios and updated format	Esteban Stelpflug	4/2/2018
1.4	Added additional Authorization Rejections and Resolutions	Esteban Stelpflug	7/9/2019