



2023

Most Common Reason Codes on Remittance Advice Talking Points

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Medicare carriers use standardized claim adjustment reason codes called "CARC" and remittance advice remark codes, called "RARC", to explain the claim processing outcomes to the providers and members. These adjustment reason and remark codes are reflected as following:

"Reason Code" with Description listed in

- ECHO Health under "EPP" Remittance Advice
- SCAN's Provider Portal under Claim Tab in Claim Details Screen

"Description Code" listed in ECHO Health under "EOD"

Self-register and gain immediate access to SCAN's enhanced provider portal by clicking [SCAN Provider Portal](#). Follow instructions and click on **Create Account** for **either** "For SCAN Contracted Providers" or "Non-Contracted Providers". Refer to specific User Guide for guidance or additional information.

1. B11 & N418

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. N418 = Misrouted claim. See the payers claim submission instructions. 	<p>1) Refer to SCAN's Provider Portal under Eligibility Tab in the “Address to Submit Claims” field to confirm responsible entity for processing of claim.</p> <p>a) Contact Delegate reflected in the “Address to Submit Claims” field for status of claim.</p> <p>2) If provider contacts the Delegate, and they state that SCAN is responsible, then provider should complete and submit Provider Dispute Form (PDR).</p> <p>a) Click on SCAN's Provider Portal to access and refer to Resources and Guidelines Tab and under the Provider Eligibility and Claims Transactions section.</p> <ul style="list-style-type: none"> Refer to the Claim Disputes & Appeal section to select appropriate PDR Form and follow instructions for submission. <p>b) Provider can also refer to Provider Section in the SCAN Health Plan Website under Provider Claim Disputes & Appeals file.</p> <ul style="list-style-type: none"> Click on How to Submit Claim Disputes & Appeals to select appropriate PDR Form and follow instructions for submission.

2. 29

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> 29 = The time limit for filing has expired. 	<p>1) If Provider disagrees with Time Limit Reason Code, provider should submit a Provider Dispute Form (PDR) along with proof/evidence of timely filing.</p> <p>a) Click on SCAN's Provider Portal to access and refer to Resources and Guidelines Tab and under the Provider Eligibility and Claims Transactions section.</p> <ul style="list-style-type: none"> Refer to the Claim Disputes & Appeal section to select appropriate PDR Form and follow instructions for submission. <p>b) Provider can also refer to Provider Section in the SCAN Health Plan Website under Provider Claim Disputes & Appeals file.</p>

	<ul style="list-style-type: none"> Click on How to Submit Claim Disputes & Appeals to select appropriate PDR Form and follow instructions for submission. <p>c) The PDR should include proof of timely filing or Good Cause reason for late filing.</p> <p>Example of Good Cause: Provider received member plan information late.</p>
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3. M127, N517 & 252

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> M127 = Missing patient medical record for this service. N517 = Resubmit a new claim with the requested information. 252 = An attachment/other documentation is required to adjudicate this claim/service. 	<p>1) In addition to information reflected on Remittance Advice (RA) and Provider Portal Claim Details, providers are also sent a written notice that specifically states what information is missing or required. Therefore, please submit the information (i.e., <u>medical records</u>, <u>corrected claim</u>, or <u>other documentation</u>) that is reflected in letter or RA or Provider Portal to below address:</p> <p>SCAN Health Plan Claims Department P. O. Box 22698 Long Beach, CA 90801-5616</p>

4. 18

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> 18 = Exact duplicate claim/service 	<p>1) If provider has reviewed RA or Provider Portal Claim Details, and disagrees with the Duplicate Reason Code, provider should submit a Provider Dispute Form (PDR).</p> <p>a) Click on SCAN's Provider Portal to access and refer to Resources and Guidelines Tab and under the <u>Provider Eligibility and Claims Transactions</u> section.</p> <ul style="list-style-type: none"> Refer to the Claim Disputes & Appeal section to select appropriate PDR Form and follow instructions for submission. <p>b) Provider can also refer to Provider Section in the SCAN Health Plan Website under <u>Provider Claim Disputes & Appeals</u> file.</p> <ul style="list-style-type: none"> Click on How to Submit Claim Disputes & Appeals to select appropriate PDR Form and follow instructions for submission.

5. 16 & N463

Reason Code include:	Guidance on Next Steps for Provider to Take
<p><u>Transplant Claims</u></p> <ul style="list-style-type: none"> 16 = Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. N463 - Missing support data for claim. 	<p>1) Our records indicate that the provider's facility is a contracted participant in Optum's Transplant Network. As such, the provider must first submit the claim to Optum for the contracted rate pricing.</p> <p>a) Claim must include the Optum pricing when submitted for payment.</p> <p>b) Provider should contact Optum at 1-877-801-3507.</p>

6. MA20

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> MA20 = Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence 	<p>Services for primarily related to the use of a urethral catheter for convenience or control of incontinence are not covered; therefore, a <u>member appeal</u> should be submitted, and <u>not a provider appeal</u>.</p>

7. 256

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> 256 = Service not payable per managed care contract 	<p>Services for out of area and non-urgent/emergent are not covered; therefore, a <u>member appeal</u> should be submitted, and <u>not provider appeal</u>.</p>

8. N115

Reason Code include:	Guidance on Next Steps for Provider to Take
<ul style="list-style-type: none"> N115 = This decision was based on a Local Coverage Determination (LCD), an LCD provides a guidance to assist in determining whether a particular item or services is covered. 	<p>This decision was based on Medicare determination; therefore, refer to Local Coverage Determinations at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs</p>