6.8 Remittance Advice Explanatory Codes

Eligibility

EA Service date is not within an eligible period - services provided on or after the 20th of this month will not be paid unless eligibility status changes

EV Check health card for current version

EF Incorrect version code - services provided on or after the 20th of this month will not be paid unless the current version code is provided

E1 Service date is prior to start of eligibility

E2 Incorrect version code for service date

E4 Service date is after the eligibility termination date

E5 Service date is not within an eligible period

J7 Claim submitted six months after service date

GF Coverage lapsed - bill patient for future claims

General

09 Fee Schedule Code(s) used is not correct – resubmit using appropriate code(s) from OHIP Schedule of Benefits

16 Premium not applicable

30 This service is not a benefit of the ministry

32 Ministry records show that this service has already been claimed for payment to the patient

35 Ministry records show this service rendered by you has been claimed previously

36 Ministry records show this service has been rendered by another practitioner, group, lab

37 Effective April, 1993 the listed benefit for this code is 0 LMS units

40 This service or related service allowed only once for same patient

48 Paid as submitted - clinical records may be requested for verification purposes

49 Paid according to the average fee for this service - independent consideration will be given if clinical records/operative reports are presented

50 Fee allowed according to the appropriate item in the current ministry Schedule of Benefits for Physician Services

51 Fee Schedule Code changed in accordance with Schedule of Benefits

52 Fee for service assessed by medical consultant

53 Fee allowed according to appropriate item in a previous ministry Schedule of Benefits

54 Interim payment claim under review

6.8 Remittance Advice Explanatory Codes (continued)

General (continued)

55 This deduction is an adjustment on an earlier account

56 Claim under review

57 This payment is an adjustment on an earlier account

58 Claimed by another physician within your group

59 Health Care Provider's notification - WCB claims

61 OOC claim paid at greater than $9999.99 (prior approval on file)

62 Claim assessed by assessment officer

65 Service included in approved hospital payment

68 Hospital accommodation paid at standard ward rate

69 Elective services paid at 75% of insured costs

70 OHIP records show corresponding procedure(s)/visit(s) on this day claimed previously

80 Technical fee adjustment for hospitals and IHFs

AP This payment is in accordance with legislation-if you disagree with the payment you may appeal

DM Paid/disallowed in accordance with ministry policy regarding emergency department equivalent

EB Additional payment for the claim shown

I2 Service is globally funded

J3 Approved for stale date processing

Q8 Laboratory not licensed to perform this test on date of service

SR Fee reduced based on ministry utilization adjustment - contact your physician/ practitioner

TH Fee reduced per ministry Payment Policy - contact your physician

6.8 Remittance Advice Explanatory Codes (continued)

Consultations

C1 Allowed as repeat/limited consultation/midwife-requested emergency assessment

C2 Allowed at reassessment fee

C3 Allowed at minor assessment fee

C4 Consultation not allowed with this service - paid as assessment

C5 Allowed as multiple systems assessment

C6 Allowed as Type 2 Admission Assessment

C7 An admission assessment C003A or general re-assessment C004A may not be claimed by any physician within 30 days following a pre-dental/pre-operative assessment

C8 Payment reduced to geriatric consultation fee – maximum number of comprehensive geriatric consultations has been reached

C9 Allowed as in-patient interim admission orders – initial assessment already claimed by other physician

Critical Care

G1 Other critical/comprehensive care already paid

Diagnostic and Therapeutic Procedures

D1 Allowed as repeat procedure; initial procedure previously claimed

D2 Additional procedures allowed at 50%

D3 Not allowed in addition to visit fee

D4 Procedure allowed at 50% with visit

D5 Procedure already allowed - visit fee adjusted

D6 Limit of payment for this procedure reached

D7 Not allowed in addition to other procedure

D8 Allowed with specific procedures only

D9 Not allowed to a hospital department

DA Maximum for this procedure reached - paid as repeat/chronic procedure

DB Other dialysis procedure already paid

DC Procedure paid previously not allowed in addition to this procedure - fee adjusted to pay the difference

DD Not allowed as diagnostic code is unrelated to original major eye exam

DE Laboratory tests already paid - visit fee adjusted

DG Diagnostic/miscellaneous services for hospital patients are payable on a fee-for-service basis - included in hospital global budget

DH Ventilatory support allowed with Haemodialysis

6.8 Remittance Advice Explanatory Codes (continued)

Diagnostic and Therapeutic Procedures (continued)

DL Allowed as laboratory test in private office

DM Paid/disallowed in accordance with MOH policy regarding an Emergency Department Equivalent

DN Allowed as pudendal block in addition to procedure as per stated policy

DP Procedure paid previously allowed at 50% in addition to this procedure - fee adjusted to pay the difference

DS Not allowed – mutually exclusive code billed

DT In-patient technical fee not allowed

DV Service is included in Monthly Management Fee for Long-Term Care Patients

DX Diagnostic code not eligible with FSC

Fractures

F1 Additional fractures/dislocations allowed at 85%

F2 Allowed in accordance with transferred care

F3 Previous attempted reductions (open or closed) allowed at 85%

F5 Two weeks aftercare included in fracture fee

F6 Allowed as Minor/Partial Assessment

Hospital Visits

H1 Admission assessment or ER assessment already paid

H2 Allowed as subsequent visit; initial visit previously claimed

H3 Maximum fee allowed per week after 5th week

H4 Maximum fee allowed per week after 6th week to paediatricians

H5 Maximum fee allowed per month after 13th week

H6 Allowed as supportive or concurrent care

H7 Allowed as chronic care

H8 Master number and/or admission date required for in-hospital service

H9 Concurrent care already claimed by another doctor

HA Admission assessment claimed by another physician - hospital visit fee applied

HF Concurrent or Supportive Care already claimed in period

HM Invalid master number used on date of service

6.8 Remittance Advice Explanatory Codes (continued)

Laboratory

L1 This service paid to another laboratory

L2 Not allowed to non-medical laboratory director

L3 Not allowed in addition to this laboratory procedure

L4 Not allowed to attending physicians

L5 Not allowed in addition to other procedure paid to another laboratory

L6 Procedure paid previously to another laboratory, not allowed in addition to this procedure - fee adjusted to pay difference

L7 Not allowed - referred specimen

L8 Not to be claimed with prenatal/fetal assessment as of July 1, 1993

L9 Laboratory services for hospital in-patients are not payable on a fee-for-service basis-included in the hospital global budget

LA Lab service is funded by special lab agreement

LS Paid in accordance to Special Lab Agreement

Paediatric Care

P2 Maximum fee allowed for low-birth weight care

P3 Maximum fee allowed for newborn care

P4 Fee for newborn/low-birth weight care is not billable with neonatal intensive care

P5 Over-age for paediatric rates of payment

P6 Over-age for well baby care

Obstetrics

O1 Fee for obstetric care apportioned

O2 Previous prenatal care already claimed

O3 Previous prenatal care already claimed by another doctor

O4 Office visits relating to pregnancy and claimed prior to delivery included in obstetric fee

O5 Not allowed in addition to delivery

O6 Medical induction/stimulation of labour allowed once per pregnancy

O7 Allowed as subsequent prenatal visit. Initial prenatal visit already claimed

O8 Allowed once per pregnancy

O9 Not allowed in addition to post-natal care

6.8 Remittance Advice Explanatory Codes (continued)

Office and Home Visits

V1 Allowed as repeat assessment - initial assessment previously claimed

V2 Allowed as extra patient seen in the home

V3 Not allowed in addition to procedural fee

V4 Date of service was not a Saturday, Sunday, or a statutory holiday

V5 Only one oculo-visual assessment (OVA) allowed within a 12-month period for age 19 and under or 65 and over and one within 24 months for age 20-64

V6 Allowed as minor assessment - initial assessment already claimed

V7 Allowed at medical/specific reassessment fee

V8 This service paid at lower fee as per stated ministry policy

V9 Only one initial office visit allowed within 12-month period

VA Procedure fee reduced. Consultation/visit fees not allowed in addition

VB Additional OVA is allowed once within the second year for patients aged 20-64, following a periodic OVA

VG Only one geriatric general assessment premium per patient per 12-month period

VM Oculo-visual minor assessment is allowed within 12 consecutive months following a major eye exam

VP Allowed with specific visit only

VS Date of service was a Saturday, Sunday or statutory holiday

VX Compexity Premium not applicable to visit fee

Radiology

X2 G.I. tract includes cine and video tape

X3 G.I. tract includes survey film of abdomen

X4 Only one BMD allowed within a 24 month period for a low risk patient

6.8 Remittance Advice Explanatory Codes (continued)

Surgical Procedures

S1 Bilateral surgery, one stage, allowed at 85% higher than unilateral

S2 Bilateral surgery, two stage, allowed at 85% higher than unilateral

S3 Second surgical procedure allowed at 85%

S4 Procedure fee reduced when paid with related surgery or anaesthetic

S5 Not allowed in addition to major surgical fee

S6 Allowed as subsequent procedure-initial procedure previously claimed

S7 Normal pre-operative and post-operative care included in surgical fee

SA Surgical procedure allowed at consultation fee

SB Normal pre-operative visit included in surgical fee - visit fee previously paid-surgical fee adjusted

SC Not allowed major pre-operative visit already claimed

SD Not allowed-team/assist fee already claimed

SE Major pre-operative visit previously paid and admission assessment previously paid - surgery fee reduced by the admission assessment

Dental Services

T1 Fee allowed according to surgery claim

Health Examinations

R1 Only one health exam allowed in a 12-month period

Maxima

M1 Maximum fee allowed or maximum number of services has been reached same/any provider

M2 Maximum allowance for radiographic examination(s) by one or more practitioners

M3 Maximum fee allowed for prenatal care

M4 Maximum fee allowed for these services by one or more practitioners has been reached

M5 Monthly maximum has been reached

M6 Maximum fee allowed for special visit premium - additional patient seen

MA Maximum number of sessions has been reached

MC Maximum of 2 patient case conferences has been reached in a 12-month period

MN Maximum allowable for sleep studies in a 12-month period by one physician has been reached

MX Maximum of 2 arthroscopy ‘R’ codes with E595 has been reached

6.8 Remittance Advice Explanatory Codes (continued)

Reciprocal Medical Billing (RMB)

60 Not a benefit of RMB agreement

RD Duplicate, paid by RMB

Independent Health Facilities (IHF) Explanatory Codes

FF Additional payment for the claim shown

I2 Service is globally funded

I3 FSC is not on the IHF licence profile for the date specified

I4 Records show this service has been rendered by another practitioner, group or IHF

I5 Service is globally funded and FSC is not on IHF licence profile

I6 Premium not applicable

I7 Claim date does not match patient enrolment date

I8 Confirmation not received

I9 Payment not applicable/expired

Inquiries

Inquiries regarding **overpayments** or **underpayments** should be made within one month of the remittance advice on which the payment appears and **must** be made and resolved within six months from the service date for any adjustments to payments to occur. Inquiries should be submitted to your ministry claims processing office (refer to Section 1.2 – Office Locations and Contact Numbers) on a Remittance Advice Inquiry (form 918-84*)*.

Resubmission of Outstanding Claims

Claims outstanding for two payment cycles after submission should be resubmitted if payment has not been reported on the remittance advice; however, claims should be submitted as soon as possible after the service is rendered because this does not apply to claims where resubmission after two payment cycles would exceed the time limits for submitting accounts as per regulatory requirements (no later than six months after the service is rendered).