IBC Coding Bulletin: Insurer Reason Codes

HCAI Insurer Reason Codes (IRCs): Changes to be implemented on June 1, 2015

When insurance adjusters make an adjudication decision related to medical and/or rehabilitation claims submitted via HCAI and the decision is not to approve the goods or services, the insurance adjusters must specify the reason behind the decision. The list of reason codes used in the HCAI application can be located in the insurer portal of the the HCAI Information website in Chapter 12 of the Insurer User Manual. As of June 1, 2015, some of these codes will no longer be available and new codes will be introduced.

Health care providers who use the online HCAI application are able to view the IRCs, allowing greater insight into the claims administration process. To learn how providers can review IRCs in the HCAI application, refer to Track My OCF under the "Adjuster Response" tab.

Why change?

In a review of IRCs conducted in 2012, insurers advised that there was room to improve the utility of the codes by improving the following:

- *Communication with health care providers*. Insurers wanted to improve their ability to communicate more effectively with providers about the reasons for denial of goods and services.
- *Analysis of data*. The old IRCs limited the ability to analyze data to examine patterns of adjudication decisions.
- *Complex code set*. The new code set is shorter and less complex and it eliminates duplicate or redundant codes. This will make the code selection process easier for insurers.
- *Longevity*. Regulations are periodically amended. The new code set has improved endurance against regulatory reform and will require fewer changes over time.

Summary of changes

1) Narrative text box available regardless of code selected
    - In 2012, a review indicated that the most prevalent reason code that insurers used was "Other" (115.05). When asked, insurers advised that they selected this code because it is associated with a text field, which the adjuster can use to communicate the reason for the decision to the health care provider. In other words, adjusters wanted to communicate the reasons behind their decisions, but narrative communication was only possible if they used the "Other" code. The new code set for IRCs includes a text field that insurers may use regardless of which decision code they select.

2) Fewer codes and elimination of duplicate or outdated codes
    - The review in 2012 also offered guidance around which codes insurers used regularly, which codes were duplicated or not required, and ways to improve the utility of the code set. As a result, the new code set is organized as shown in Table 1. The code set was reduced from 5 classes to 3 in order to simplify the insurer's ability to select the appropriate reason codes. In addition, a number of duplicate codes were eliminated and the descriptions associated with many codes have been updated to better reflect the reason for the decision.

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Table 1: Organization of old and new reason codes

	Prior to June 1, 2015	Beginning June 1, 2015
Classes	Adjuster decision Adjuster decision update Pending Withdrawn Information	Unable to authorize – administrative Adjuster decision Other
Number of subclasses	29	12
Number of codes	90	53
Text field	Available with 1 code	Available with any code

In June 2015, the above codes will be updated. Insurers and health care providers may wish to familiarize themselves with the changes now in order to prepare for the HCAI release on June 1, 2015, when the new code sets will be available. It is anticipated that with fewer classes and fewer codes, insurers will be able to locate an appropriate reason code rather than relying on the code "Other," which does not offer insight into why goods or services were denied. The new IRCs follow on the next page.

Class: Unable to Authorize

This class of codes captures situations where the insurer is not able to approve a benefit, in most cases because paperwork, documentation or information is not available to render an adjudication decision. The subclasses include:

Subclass	Code	Description
Documentation, Policy, Claim or Claimant Information	1.10.00	Supporting information insufficient, incomplete or incorrect
	3.00.00	Application for benefits missing or incomplete
	3.00.05	Statement under oath not yet complete
	3.00.25	Statutory declaration not received
	1.40.05	Patient failed to comply with authorized procedures (e.g., examination under oath or insurer examination)
	1.11.00	Does not match claimant information
	1.00.10	No record of authorization
	1.40.00	Guideline documentation required – see explanation
	1.11.05	Policy or coverage identity error
Waiting for Opinion, Ruling or Agreement	3.03.00	Waiting for binding medical opinion
	3.03.05	Waiting for arbitration or litigation ruling
	3.03.10	Waiting for resolution of conflict of interest
	3.03.15	Waiting for agreement by all parties
Administrative	1.04.15	Transferred to another provider
	1.08.00	Duplicate good or service from other provider
	1.08.05	Duplicate form, good or service from same provider
	1.11.20	Patient must claim reimbursement
	1.05.00	Date of service precedes date of loss
	1.05.10	Billing date precedes date of service
	1.35.00	Invoice applies to more than one plan
	1.09.10	Service or procedure time adjustment

Class: Adjuster Decision

This class addresses adjudication decisions including but not limited to circumstances where the insurer determines that a benefit is not payable.

Subclass	Code	Description
Withdrawn	4.10.00	Withdrawn on behalf of the claimant, provider or insurer – see explanation for who withdrew
Claim Settled	1.07.05	Expenses are not payable based on settlement agreement
Authorization, Policy Limits, Coverage	1.01.00	Good or service requires prior authorization
	1.11.15	Policy coverage limits have been exhausted
	1.05.05	Time limit for filing has expired
	1.09.05	Fee exceeds maximum allowed
	1.04.45	Good or service is not covered within the *Minor Injury Guideline*
	1.04.50	Good or service is not separately reimbursable within the *Minor Injury Guideline*
	1.02.00	Authorized quantity exceeded
	1.03.05	Authorized time period exceeded
	1.11.10	Transportation deductible has not been exceeded
	1.11.25	Good or service is not covered
	1.02.05	Authorized amount exceeded
Other Insurance Coverage	1.13.00	Collateral insurance information is missing or incorrect
	3.01.15	Claimant is receiving WSIB benefits
	3.01.10	Patient has other coverage (e.g., priority with other insurer)
Fees and Taxes	1.09.00	Fee exceeds reasonable fee for good or service
	1.12.10	Interest is incorrect or not applicable
	1.12.15	Tax is incorrect or not applicable
Guidelines	1.30.00	Claimant not eligible for service – see explanation
	1.04.60	Diagnosis indicates that the *Minor Injury Guideline* is appropriate
Not Reasonable and Necessary	1.07.00	Not reasonable and necessary
	1.30.05	Diagnosis inconsistent with cause of loss, procedure or provider – see explanation
	1.30.15	Non-medical reason(s) – see explanation of benefits statement or correspondence with claimant

Subclass	Code	Description
	1.30.10	Medical reason(s) – see explanation of benefits statement or correspondence with claimant
	1.07.15	Good or service is inconsistent with the cause of loss
Decision Update	2.00.00	Decision updated in accordance with a medical opinion
	2.00.05	Decision updated in accordance with a binding arbitration or litigation ruling
	2.00.10	Decision updated based on new information received
	2.00.15	Decision updated because of conflict of interest
	2.00.20	Decision updated based on agreement by all parties

Class: Other

Other	1.15.05	Other – see explanation