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| <b>CMS Manual System</b>                | <b>Department of Health &amp; Human Services (DHHS)</b>   |
| <b>Pub 100-20 One-Time Notification</b> | <b>Centers for Medicare &amp; Medicaid Services (CMS)</b> |
| <b>Transmittal 13706</b>                | <b>Date: March 31, 2026</b>                               |
|   | <b>Change Request 14318</b>                               |

**Transmittal 13621 issued February 11, 2026, is being rescinded and replaced by Transmittal 13706, dated March 31, 2026, to update two business requirements, 14318.3.2 and 14318.4.2, as identified by VMS. All other information remains the same.**

**SUBJECT: Medicare Administrative Contractors (MACs) Part B, the Multi- Carrier System (MCS) and Durable Medicare Equipment (DME) MACs Updates on Processing Medicare Secondary Payer (MSP) Claims Containing Certain Claim Adjustment Reason Codes (CARCs)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to instruct Part B MACs and Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) on how to process MSP claims containing certain CARCs as identified in this CR. Part B and DME MACs process MSP claims containing CARCs based on previous CMS instructions. Over the years, many of these CARCs were processed through automation, denied, or suspended for manual review.

However, after recent discussions held with the Part B MACs, several CARCs can now be processed through automation without manual intervention while others will continue to be suspended. The change request identifies those CARCs codes that will be processed through automation and those that will be suspended for manual review or even denied.

**EFFECTIVE DATE: July 1, 2026**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: July 6, 2026**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| <b>R/N/D</b> | <b>CHAPTER / SECTION / SUBSECTION / TITLE</b> |
|--------------|---|
| N/A          | N/A   |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

#### **IV. ATTACHMENTS:**

##### **One Time Notification**

# Attachment - One-Time Notification

|             |                    |                      |                       |
|-------------|--------------------|----------------------|-----------------------|
| Pub. 100-20 | Transmittal: 13706 | Date: March 31, 2026 | Change Request: 14318 |
|-------------|--------------------|----------------------|-----------------------|

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## II. GENERAL INFORMATION

**A. Background:** The changes herein addressed are necessary to ensure Medicare's compliance with the Health Insurance Portability Act (HIPAA) transaction and code set requirements and to ensure that MSP claims are properly calculated by the Medicare contractors and their associated shared systems using payment information derived from the incoming 837 Professional claim. MSP policy also dictates what the shared systems and contractors must take into consideration when processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claim Adjustment Segment (CAS) on the 835 Electronic Remittance Advice (ERA) or paper remittance. The provider must take the CAS segment adjustments, as found on the 835 and report these adjustments on the 837 unchanged, when sending the claim to Medicare for secondary payment. Part B and DME MACs must use CAS segment adjustment amounts in determining MSP payment on MSP claims using CARCs found in the CAS segment.

**B. Policy:** Part B and DME MACs and associated shared systems must utilize the CARCs adjustments on the 837 when adjudicating MSP claims.

## III. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number    | Requirement  | Responsibility |   |     |            |                           |     |     |     |       |
|-----------|--|----------------|---|-----|------------|---------------------------|-----|-----|-----|-------|
|           |  | A/B MAC        |   |     | DME<br>MAC | Shared-System Maintainers |     |     |     | Other |
|           |  | A              | B | HHH |            | FISS                      | MCS | VMS | CWF |       |
| 14318.1   | The PartB and DME MACs and designated shared systems shall update their processes and tables to process the below CARCs found on MSP claims as discussed in the previous MSP calls.  |                | X |     | X          |                           | X   |     |     |       |
| 14318.2   | MCS shall update the following CARCs on the H99TSTND to include an MSP Action Code of 'D' (Deny):<br>5, 6, 7, 8, 9,12,18,53,97, 107, 116, 148, 171, 183, 185, 193, 224, 250, 251, 252, 285, 286, 300, 301, 304, 305, B12, B13, P30, P7   |                |   |     |            |                           | X   |     |     |       |
| 14318.2.1 | DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of "N" in the MSP CAS field, which denotes that they deny MSP services when the following CARCs are found on MSP claims:<br>5, 6, 7, 8, 9, 12, 18, 53, 97, 107, 116, 148, 171, 183, 185, 193, 224, 250, 251, 252, 285, 286, 300, 301, 304, 305, B12, B13, P30, P7 |                |   |     | X          |                           |     |     |     |       |
| 14318.3   | Part B MACs and designated shared system shall accept and process for MSP services when the following CARCs are found on MSP claims. Note that these claims may still be suspended or denied for reasons other than the listed CARCs:<br><br>23, 33, 40, 109, 172, 178, B20, B22   |                | X |     |            |                           | X   |     |     |       |
| 14318.3.1 | MCS shall update the CARCs in above BR 3 on the  |                |   |     |            |                           | X   |     |     |       |

| Number    | Requirement   | Responsibility |   |     |            |                           |     |     |     |       |
|-----------|---|----------------|---|-----|------------|---------------------------|-----|-----|-----|-------|
|           |   | A/B MAC        |   |     | DME<br>MAC | Shared-System Maintainers |     |     |     | Other |
|           |   | A              | B | HHH |            | FISS                      | MCS | VMS | CWF |       |
|           | H99TSTND to remove the MSP Action Code.   |                |   |     |            |                           |     |     |     |       |
| 14318.3.2 | DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of “S” in the MSP CAS field, which denotes that they pay secondary for MSP services, when the following CARCs are found on MSP claims:<br><br>23, 33, 40,<br>109, 172, 178, B20, B22     |                |   |     | X          |                           |     |     |     |       |
| 14318.4   | Part B MACs and designated shared system shall suspend MSP claims for manual review for MSP services when the following CARCs are found on MSP claims. Note that these claims may still be denied by the claims processing system:<br><br>26, 31, 32,<br>166, 200, 242, 256, P1         |                | X |     |            |                           | X   |     |     |       |
| 14318.4.1 | MCS shall update the CARCs in above BR 4 on the H99TSTND to include an MSP Action Code of ‘S’ (Suspend).  |                |   |     |            |                           | X   |     |     |       |
| 14318.4.2 | DME MACs shall set up the following CARCs on the VMAP/4C/ANSILIST detail screen with the value of “R” in the MSP CAS field, which denotes that they suspend for review the MSP services, when the following CARCs are found on MSP claims:<br><br>26, 31, 32,<br>166, 200, 242, 256, P1 |                |   |     | X          |                           |     |     |     |       |
| 14318.5   | DME MACs shall add the adjustment amount to the payment amount when CARC  |                |   |     | X          |                           |     |     |     |       |

| Number    | Requirement  | Responsibility |   |     |            |                           |     |     |     |       |
|-----------|--|----------------|---|-----|------------|---------------------------|-----|-----|-----|-------|
|           |  | A/B MAC        |   |     | DME<br>MAC | Shared-System Maintainers |     |     |     | Other |
|           |  | A              | B | HHH |            | FISS                      | MCS | VMS | CWF |       |
|           | 308 is received on an MSP Claim.   |                |   |     |            |                           |     |     |     |       |
| 14318.5.1 | This Business Requirement is deleted.  |                | X |     |            |                           | X   |     |     |       |
| 14318.5.2 | DME MACs shall set up the CARC 308 on the VMAP/4C/ANSILIST detail screen with the value of "A" in the MSP CAS field, which denotes that they add the CARC 308 adjustment amount to the paid amount found on MSP claim. |                |   |     | X          |                           |     |     |     |       |
| 14318.6   | Contractors shall be aware that all other CARCs processes and procedures identified in previous CRs, but not mentioned in this CR, are not being updated.  |                | X |     | X          |                           |     |     |     |       |

**IV. PROVIDER EDUCATION**

None

**Impacted Contractors:** None

**V. SUPPORTING INFORMATION**

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|--------------------------|--|
|                          |  |

**Section B: All other recommendations and supporting information:** N/A

**VI. CONTACTS**

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## **VII. FUNDING**

### **Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 1**

| STANDARD Code | Standard Code Desc1   | Standard Code Desc2   | Standard End Date | MSP System Action: A/P = Pay - Process without denying, B/D/E/W = Deny S = Suspend | New System action: D = Deny S = Suspend P = Continue to Process      | CGS                 | FC/Novitas                   | NGS  | Noridian                                  | Palmetto/RR   | WPS   |   |
|---------------|---|---|-------------------|--|--|---------------------|------------------------------|--|---|---|---|---|
| B12           | SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORD   | DS.   | 0                 | S  | D - All agreed   |                     |                              |  |   |   |   |   |
| B13           | PREVIOUSLY PAID, PAYMENT FOR THIS CLAIM/SERVICE MADE  | Y HAVE BEEN PROVIDED IN A   | 0                 | S  | D - All agreed   |                     |                              |  |   |   |   |   |
| 107           | THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT IDENTIFIED ON THIS CLAIM.   | IDENTIFIED ON THIS CLAIM.   | 0                 | S  | D - All agreed   |                     |                              |  |   |   |   |   |
| 116           | THE ADVANCE INDEMNIFICATION NOTICE SIGNED BY THE PATIENT DID NOT COMPLY WITH THE REQUIREMENTS OF THE POLICY.  | ATIENT DID NOT COMPLY WITH  | 0                 | S  | D - All agreed   | Pay - Agree to deny | Denies                       | deny   | deny                                      | Pay - Agree to deny   | Deny  |   |
| 126           | THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TYPE.   | PE. USAGE: REFER TO THE INFORMATION FROM ANOTHER PROVIDER WAS NOT PROVIDED                        | 0                 | S  | D - All agreed   | Deny                | deny                         | deny   | deny                                      | ok to deny  | deny  |   |
| 148           | PAYMENT IS DENIED WHEN EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP)  | OR WAS INSUFFICIENT/INCOMPLETE OF PROVIDER IN THIS TYPE   | 0                 | S  | D - All agreed   | pay                 | deny                         | deny   | pay                                       | deny  | pay   |   |
| 171           | THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE PATIENT TO THIS SERVICE.  | E SERVICE BILLED.   | 0                 | S  | D - All agreed   | pay                 | deny                         | deny   | pay                                       | pay   | pay   |   |
| 185           | THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED.   | THE SERVICE BILLED.   | 0                 | S  | D - All agreed   | pay                 | deny                         | deny   | pay                                       | deny  | pay   |   |
| 193           | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED, UPON REVIEW, IT WAS DETERMINED THAT THE PATIENT IDENTIFICATION COMPROMISED BY IDENTIFY VERIFICATION. | N REVIEW, IT WAS DETERMINED THAT THE PATIENT IDENTIFICATION COMPROMISED BY IDENTIFY VERIFICATION. | 0                 | S  | D - All agreed   |                     |                              |  |   |   |   |   |
| 224           | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PATIENT'S ALLOWANCE FOR ANOTHER SERVICE.  | YMENT/ALLOWANCE FOR ANOTHER   | 0                 | S  | D - All agreed   | Deny                | suspend - review.            | deny   | deny                                      | pay   | suspend and review                            |   |
| 227           | SERVICES BY AN IMMEDIATE RELATIVE OR A MEMBER OF THE SAME HOUSEHOLD ARE NOT ELIGIBLE TO BE BILLED FOR THE SAME SERVICE.                             | HE SAME HOUSEHOLD ARE NOT   | 0                 | P  | D - All Agreed   | Deny                | P                            | deny D445  | Pay                                       | DENY  | deny  |   |
| 5             | THE PROCEDURE CODE/TYPE OF BILL IS INCONSISTENT WITH THE PLACE OF SERVICE.  | TH THE PLACE OF SERVICE.  | 0                 | S  | D - all agreed. Provider must submit correctly to Primary Insurance. | deny                | Deny                         | deny   | Pay but would be ok to deny               | RESEARCH PROCEDURE CODE - If Medicare allows based on place of service - pay If Medicare does not allow based on place of service - the system should have auto-denied. If not denied, Palmetto would manually deny | Not in attendance                             | If same for Medicare, leave the denial, if no denial then pay |
| 6             | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE.  | E PATIENT'S AGE.  | 0                 | S  | D - all agreed. Provider must submit correctly to Primary Insurance. | deny                | Deny                         | deny   | Pay but would be ok to deny               | RESEARCH PROCEDURE CODE - If Medicare allows based on beneficiary age - pay If Medicare does not allow based on beneficiary age the system should have auto-denied. If not denied, Palmetto would manually deny     | Not in attendance                             | If same for Medicare, leave the denial, if no denial then pay |
| 7             | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER.   | E PATIENT'S GENDER.   | 0                 | S  | D - all agreed. Provider must submit correctly to Primary Insurance. | deny                | Deny                         |  | Pay but would be ok to deny               | RESEARCH PROCEDURE CODE - If Medicare allows based on beneficiary Sex - pay If Medicare does not allow based on beneficiary sex the system should have auto-denied. If not denied, Palmetto would manually deny     | Not in attendance                             | If same for Medicare, leave the denial, if no denial then pay |
| 8             | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY).   | ER TYPE/SPECIALTY (TAXONOMY)  | 0                 | S  | D - all agreed. Provider must submit correctly to Primary Insurance. | deny                | Deny                         | deny   | Pay but would be ok to deny               | PAY   | Not in attendance                             | If same for Medicare, leave the denial, if no denial then pay |
| 9             | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.   | GE. USAGE: REFER TO THE SUPPORTING DOCUMENTATION WAS NOT COMPLETED                                | 0                 | S  | D - all agreed. Provider must submit correctly to Primary Insurance. | deny                | Currently suspend and review | deny   | Pay but would be ok to deny               | PAY   | Not in attendance                             | If same for Medicare, leave the denial, if no denial then pay |
| P30           | PAYMENT DENIED FOR EXACERBATION WHEN SUPPORTING DOCUMENTATION WAS NOT COMPLETED   | UMENTATION WAS NOT COMPLETED  | 0                 |  | D-All agree  | suspend and review  | LxLiability                  |  | Pay                                       | CMS INPUT   | CMS Input                                     |   |
| P7            | THE APPLICABLE FEE SCHEDULE/FEE DATABASE DOES NOT CONTAIN THE BILLED CODE.  | CONTAIN THE BILLED CODE.  | 0                 |  | D-All agree  | suspend and review  | LxLiability                  | Need RARC or deny  | Pay                                       | CMS INPUT   | CMS Input                                     |   |
| 250           | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS THE INCORRECT ED WAS INCOMPLETE OR DEFICIENT.  | ED WAS THE INCORRECT ED WAS INCOMPLETE OR DEFICIENT   | 0                 |  | Deny - All agree   | suspend and review  | A+Pay                        |  | Pay                                       | DENY  | deny  |   |
| 251           | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT.   | ED WAS INCOMPLETE OR DEFICIENT  | 0                 |  | Deny - All agree   | suspend and review  | A+Pay                        |  | Pay                                       | DENY  | deny  |   |
| 252           | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICES.  | ADJUDICATE THIS CLAIM/SERVICES  | 0                 |  | Deny - All agree   | suspend and review  | A+Pay                        | Deny D928 if no primary payment  | Pay                                       | DENY  | deny  |   |
| 285           | APPEAL PROCEDURES NOT FOLLOWED.   |   | 0                 |  | Deny - All agree   | suspend and review  | D=Deny                       |  | Pay                                       | DENY  | deny  |   |
| 286           | APPEAL TIME LIMITS NOT MET.   |   | 0                 |  | Deny - All agree   | suspend and review  | D=Deny                       |  | Pay                                       | DENY  | pay   |   |
| 300           | CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN.   | NOT AVAILABLE UNDER THIS PLAN   | 0                 |  | Deny - All agree   | suspend and review  | P=Pay                        |  | Pay                                       | DENY  | Pay   |   |
| 304           | CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN.   | OT AVAILABLE UNDER THIS PLAN  | 0                 |  | Deny - All agree   | suspend and review  | D=Deny                       |  | Pay                                       | DENY  | Pay   |   |
| 305           | CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN.   | OT AVAILABLE UNDER THIS PLAN  | 0                 |  | Deny - All agree   | suspend and review  | D=Deny                       |  | Pay                                       | DENY  | Pay   |   |
| 109           | Claim not covered by this payer/contractor. You must send the claim to the appropriate payer.   | st send the claim to the appropriate payer.   | 0                 | S  | P - All agreed   | CGS - Denies        | Pays                         | NGS - Review and Denies/Pay/ECRS   | Hold Claim until ECRS, if no response Pay | Pay   | Hold Claim until ECRS, if no response Pay     |   |
| 172           | PAYMENT IS ADJUSTED WHEN PERFORMED/BILLED BY A PROVIDER OF THIS SPECIALTY.  | VIDER OF THIS SPECIALTY   | 0                 | S  | P - All agreed   | pay                 | Pays                         | pay  | pay                                       | pay   | pay   |   |
| 178           | PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIREMENTS.   | EMENTS.   | 0                 | S  | P - All agreed   |                     | deny                         | deny   | pay                                       | pay   | pay   |   |
| 23            | THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDING PAYMENTS AND/OR ADJUSTMENTS.  | G PAYMENTS AND/OR ADJUSTMENTS   | 0                 | S  | P - All agreed   | Deny - ok to Pay    | pay as prime                 | pay  | pay                                       | pay   | pay   |   |
| 33            | INSURED HAS NO DEPENDENT COVERAGE.  |   | 0                 | S  | P - All agreed   | suspend and review  | Pay                          | suspend and review   | Pay but would be ok to deny               | suspend and review  | Not in attendance                             | send ECRS is record is open; if not pay prime                 |
| 40            | CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY/URGENT CARE. USAGE: REFER TO THE POLICY.   | ENT CARE. USAGE: REFER TO THE POLICY  | 0                 | S  | P - All agreed   | pay                 | pay                          | suspend and review   | Pay but would be ok to deny               | suspend and review - PAY  | Not in attendance                             | pay   |
| B20           | PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.   | BY ANOTHER PROVIDER.  | 0                 |  | P-All Agreed   | suspend and review  | D=Deny                       | pay  | Pay                                       | LEAVE BLANK   | pay   |   |
| B22           | THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.  |   | 0                 |  | P-All Agreed   | suspend and review  | P=Pay                        | pay  | Pay                                       | LEAVE BLANK   | pay   |   |
| 166           | These services were submitted after this payer's responsibility for processing.   | responsibility for processing   | 0                 | P  | S - All agreed   | pay                 |                              | While we currently do P for this, questioning because eligibility related. CMS weigh in? | suspend and review                        | Pay   | pay   |   |
| 200           | Expenses incurred during lapse in coverage.   |   | 0                 | P  | S - All agreed   | Pay                 | P                            | suspend and review   | Pay                                       | SUSPEND FOR FURTHER REVIEW  | pay   |   |
| 242           | SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS.  | VIDERS.   | 0                 | P  | S - All agreed   |                     | P                            | suspend and review   | Agree to suspend                          |   | pay   |   |
| 256           | SERVICES NOT PAYABLE PER MANAGED CARE CONTRACT.   |   | 0                 | P  | S - All agreed   | Deny                | P                            | suspend and review   | Suspend like 242                          | AGREE   | pay   |   |
| 26            | Expenses incurred prior to coverage.  |   | 0                 | P  | S - All agreed   | Pay - may send ECRS | P                            | suspend and review   | Pay                                       | SUSPEND FOR FURTHER REVIEW  |   |   |
| 31            | PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.  |   | 0                 | P  | S - All agreed   | Deny                | P                            | suspend and review   | Suspend; review; deny or pay              | SUSPEND FOR FURTHER REVIEW  | send ECRS is record is open; if not pay prime |   |
| 32            | OUR RECORDS INDICATE THE PATIENT IS NOT AN ELIGIBLE DEPENDENT.  | E DEPENDENT.  | 0                 | P  | S - All agreed   | Deny - ok to Pay    | P                            | pay  | Pay                                       | SUSPEND FOR FURTHER REVIEW  | send ECRS is record is open; if not pay prime |   |
| P1            | STATE-MANDATED REQUIREMENT FOR PROPERTY AND CASUALTY.   | TY, SEE CLAIM PAYMENT REM   | 0                 |  | S-All Agree  | suspend and review  | LxLiability                  | Need RARC or deny  | Suspend and review                        | CMS INPUT   | CMS Input                                     |   |