# Electronic Claims Submission

## Coordination of Benefits (COB) Adjustment Reason Codes and Adjustment Group Code Categorization Table

### Aetna Provider eSolutions℠

**Working Electronically With Us**

**Overview of Document Content**

This document provides an outline of the commonly used categories for claim and line level adjustments found on paper remittances, along with some correlating industry standard Adjustment Reason Codes values and Adjustment Group Code value. These codes are needed on **your secondary claim submission to Aetna** in order to provide information on a previous payer's payment. If the previous payer sent a HIPAA standard 835 ERA these codes will be present in the ERA and can simply be transferred to the claim. If the remittance advice was sent in another form, it may be necessary to translate into these codes. The information in this document can assist you in converting payment information found on an EOB into industry standard coding.

Adjustment Reason Code values and their definitions can be found at www.wpc-edi.com. Where a general code is found for a category it is listed in **bold**. If all that is known about the previous payer's adjustment seems to be related to a category listed below, for Aetna's purposes, sending the general code listed in **bold** will usually provide the information needed to adjudicate the claim. Other codes listed might be applicable if more detail is known about the situation, or if the code was sent in an 835.

***** Please note that the information contained in this document should be used in conjunction with secondary claim submissions to Aetna, Inc. The information contained in this document was not verified with other health insurance companies and what they need to receive for their secondary claim submissions.**

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## Coordination of Benefits (COB) Adjustment Reason Codes and Adjustment Group Code Categorization Table

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*Contains adjustment reason codes assigned by the Codes Committee through revisions applied on 11/01/2009.

| Category | Adjustment Group Code Value | Adjustment Reason Code Value(s) |
|---|---|---|
| Coinsurance<br>- Member's plan coinsurance rate applied to allowable benefit for the rendered service(s). | **PR** | **2**, 127 |
| Exceeded Reasonable & Customary Amount<br>- Provider's charge for the rendered service(s) exceeds the Reasonable & Customary amount. | **PR** | **42** – Use adjustment reason code **45**, effective 06/01/07. |
| Deductible<br>- Member's plan deductible applied to the allowable benefit for the rendered service(s). | **PR** | **1**, 25, 66, 126 |
| Co-payment<br>- Member's plan co-payment applied to the allowable benefit for the rendered service(s). | **PR** | **3** |
| Interest Amount<br>- Patient Interest Amount. Note: Only use when the payment of interest is the patient's responsibility. | **PR** | **85** |
| Contracted/Negotiated Rate or Reasonable & Customary Amount<br>- Provider's charge either exceeded contracted or negotiated agreement (rate, maximum number of hours, days or units) with the payer, exceeded the reasonable & customary amount for the rendered service(s). Use this category when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment that the member is not responsible for, *or* the provider's charge exceeds the reasonable & customary amount and for which the patient is responsible. | **PR** should be sent if the adjustment amount is the patient's responsibility.<br><br>**CO** should be sent if the adjustment is related to the contracted and/or negotiated rate. | 24, **45**, 139, 147, 222, 232 |

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|---|---|---|
| Non-Covered Charge/Service Denied<br>- Provider's charge is not covered by the member's plan. | **PR** should be sent if the adjustment amount is the patient's responsibility.<br><br>**CO** should be sent if the adjustment is related to the contracted and/or negotiated rate. | 19, 20, 21, 35, 29, 38, 39, ***45**, 47,49, 50, 51, 52, 53, 54, 55, 56, 60, ***96**, 97, 106, 107, 111, 113, 114, 116, 119, 128, 138, 149, 155, 165, 190, 191, 192, 205, 211, 212, 213, 231, A1, A6, A8, B1, B7, B9, B14, B23<br>***96** *should be sent if the adjustment amount is the patient's responsibility.*<br>***45** *should be sent if the adjustment is related to the contracted/ negotiated rate.* |
| Partial Payment/Denial<br>- Payment was either reduced or denied in order to adhere to policy provisions/restrictions. | **PR** should be sent if the adjustment amount is the patient's responsibility.<br><br>**CO** should be sent if the adjustment is related to the contracted/negotiated rate. | 40, 44, ***45**, 58, 59, 61, 62, 74, 75, 78, 90, 91, 95, ***96**, 102, 104, 105, 108, 112, 115, 117, 118, 121, 122, 130, 132, 134, 137, 141, 143, 144, 145, 150, 151, 152, 153, 154, 157, 158, 159, 160, 163, 164, 169, 173, 174, 175, 176, 186, 193, 194, 196, 197, 198, 202, 203, 210, A7, B4, B5, B8, B10, B15, B16, B20, B22<br>***96** *should be sent if the adjustment amount is the patient's responsibility.*<br>***45** *should be sent if the adjustment is related to the contracted/ negotiated rate.* |
| Patient Not Covered By Other Plan<br>- Benefits were not considered by the other payer because patient is not covered *or*<br>- Claim adjusted based on failure to follow prior payer's coverage rules | **OA** | 26, 27, 31, 32, 33, 34, 136, 162, 166, 177, 200<br>Note: If this category applies to the claim/line scenario the user will need to send the specific code value. See www.wpc-edi.com to view each codes description |

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| Category | Adjustment Group Code Value | Adjustment Reason Code Value(s) |
|---|---|---|
| Discount Rate<br>- Provider offered a discount to member for the service(s) rendered. Member not responsible for this adjustment. | **OA** | 103, **131** |
| Indian Health Service - Patient Coinsurance or Deductible<br>- Per Section 630 of the Medicare Modernization Act (MMA) which permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients. This new reason code enables Medicare to communicate the message that coinsurance or deductible cannot be collected from the patient. | **OA** | **209** |
| Already Considered By Another Payer<br>- The charge was already considered by a previous payer. | **OA** | **22**, 23 |
| Paid in Excess of Charge<br>- Payment for rendered service(s) exceeded provider's charge. | **PI** | **94** |
| Partial/Full Payment from Primary Payer<br>- Payment was either reduced or denied in order to adhere to policy provisions/restrictions. | **PI** | **100** |
| Workers' Compensation Codes – The adjustment reason codes listed in this section are used strictly for the adjudication of workers' compensation claims. Secondary claims should not be submitted when a workers' compensation carrier denies benefits using these codes. | | 214, 217, 218, 219, 220, 221, D22 |

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| Category | Adjustment Group Code Value | Adjustment Reason Code Value(s) |
|---|---|---|
| Federal, State or Local Law/Regulations | OA | 223 |
| Other adjustment reason code values that are not accounted for in this table are:<br>a) informational messages provided by the payer that do not need to be sent for secondary benefit consideration, or<br>b) corrective action is needed by the provider for the claim/service and should not be sent in for secondary benefit consideration until the issue is resolved by the primary payer. | Not Applicable | See www.wpc-edi.com list |