Remittance Advice Explanatory Codes/Messages

Ministry of Health

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Ontario

Remittance Advice Explanatory Codes/Messages

Remittance advice explanatory codes/messages clarify payment exceptions found in a monthly remittance advice statement of approved claims. These codes are at times referred to simply as “Explan codes”.

Remittance Advice Explanatory Code	Description
09	Fee Schedule Code(s) used is not correct, please resubmit claim with the appropriate FSC or submit an RAI if the claim is posted on a Remittance Advice
30	Service is not a benefit of OHIP (Ontario Health Insurance Plan)
31	Not a valid network service
32	OHIP records show service(s) on this day claimed previously
33	Approved
35	OHIP records show this service rendered has been claimed previously (used on Pay Practitioner duplicate claims)
36	OHIP records show service has been rendered by another Practitioner, Group, Lab
37	Effective April 1, 1993 the listed benefit for this code is 0 Laboratory Medicine Services (LMS) units
40	Service or related service allowed only once for same patient
41	Fee Schedule Code (FSC) Billed - No Evidence in Supporting Documentation Provided
42	FSC Billed Included in Other Procedure
45	Specialty code restriction on Fee Schedule Code
46	Paid Per 2nd Review by Medical Advisor (MA)
47	Not Paid Per 2nd Review by Medical Advisor (MA)

Remittance Advice Explanatory Code	Description
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 presented.
50	Paid in accordance with the Schedule of Benefits
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 Schedule of Benefits
54	Interim payment - claim under review
55	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 group
59	Practitioner's notification - WCB claims
60	Not a benefit of the Reciprocal Medical Billing Agreement
62	Claim assessed by Assessment Officer
65	Service included in approved hospital payment
66	Reduced per Alternative Payment Program (APP) Funding Contract
69	Elective Services Paid At 75% Of OHIP Schedule of Rates
70	OHIP records show corresponding procedure(s) on this day claimed previously by another physician
80	Technical fee adjustment for hospitals

Remittance Advice Explanatory Code	Description
AP	This payment is in accordance with legislation. If you disagree with the payment, you may appeal to the General Manager
AH	Not allowed in addition to health exam
B1	Service Not Eligible for Payment When Delivered by Telephone
B2	Paid in accordance with the OHIP Schedule of Benefits for Telephone Virtual Care Services
B3	Patient-Physician Relationship Requirements Not Met
B4	Virtual Service not allowed in addition to In-Person Equivalent Service
B5	In-Person Service Not Allowed in Addition to Virtual Equivalent Service
B6	Limited Virtual Care Service Already Paid
B7	Comprehensive Virtual Care Service Already Paid
B8	Service Not Eligible for Payment Virtually
C1	Allowed as repeat/limited consultation/midwife-requested emergency assessment
C2	Allowed at re-assessment 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

Remittance Advice Explanatory Code	Description
C9	Allowed as in-patient interim admission orders-initial assessment already claimed by other physician
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 eye exam
DE	Lab tests already paid-visit fee adjusted
DF	Corresponding fee code was not billed or paid at zero
DG	Diagnostic/Miscellaneous services for hospital patients are not payable on a fee-for-service basis in the Hospital Global budget.
DH	Ventilatory support allowed with Haemodialysis
DL	Allowed as laboratory tests in private office

Remittance Advice Explanatory Code	Description
DM	Paid/disallowed in accordance with MOH policy regarding an Emergency Department Equivalent
DN	Allowed as pudenal block in addition to procedure-as per stated OHIP 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
DR	Self-Referred Diagnostic Services Payable at 50%
DV	Service is included in Monthly Management Fee for Long-Term Care (LTC) patients
DW	Procedure paid previously not allowed in addition to monthly management. For long-term care patients-fee adjusted to pay the difference.
DX	Diagnostic code not eligible with Fee Schedule Code
E1	Service date prior to start of eligibility
E2	Incorrect version code for service date
E3	Version Code not on File for HN (Health Number)
E4	Service date after the eligibility termination date
E5	Service date not within an eligible period
E6	Service Date after Eligibility End Date - Eligibility Terminated as MOH Records Indicate Patient Deceased
E9	Service Date after Eligibility End Date - Eligibility Terminated Due to no Response to Notice to Register
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

Remittance Advice Explanatory Code	Description
EB	Coding added/changed in accordance with Schedule of Benefits
EE	Assessment Allowed at Full Fee for Patient Proceeding to Hospital
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
EN	Network billing not allowed
EP	This payment is an adjustment of an earlier account due to provider registration update
EV	Check health card for current version code
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
FF	Additional payment for the claim shown
G1	Other critical/comprehensive care already paid
GF	Coverage lapsed-bill patient for future claims
H1	Admission assessment or Emergency department 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 pediatricians
H5	Maximum fee allowed per month after the 13th week
H6	Allowed as supportive or concurrent care

Remittance Advice Explanatory Code	Description
H7	Allowed as chronic care
H8	Hospital 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
HB	Subsequent Visit Already Paid Same Day
HF	Concurrent or supportive care already claimed in period
HM	Invalid master number used on date of service
I2	Service is globally funded
I3	Fee Schedule Code is not on the IHF (Independent Health Facility) licence profile for the date specified
I4	Records show service has been rendered by another Practitioner, Group or IHF
I5	Service is globally funded and Fee Schedule Code 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
ID	Physician De-Rostered Patient
IG	Service Date Ineligible
IH	Prior Enrolment History Exists
J1	Service Date is Before the Effective Date of OHIP Coverage
J2	Service Date is After the Termination of Coverage Date

Remittance Advice Explanatory Code	Description
J3	Approved for stale dated processing
J5	Coverage Applied For; Premiums Not Yet Paid
J7	Claim submitted three months after service date
J8	Coverage Not In Effect; Services Provided On Or After The 20th Of This Month Will Not Be Paid Unless Subscriber Takes Corrective Action
J9	Coverage Reinstated. Submit Claims Routinely
L1	This service paid to another laboratory
L2	Not allowed to medical Laboratory Director
L3	Not allowed in addition to other laboratory procedure(s)
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 this procedure-fee adjusted to pay the difference
L7	Not allowed-referred specimen
L8	Not to be claimed with prenatal/fetal assessment
L9	Laboratory services for hospital in-patients or out-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
M1	Maximum fee allowed or maximum number of service has been reached same/any provider
M2	Maximum allowance for radiographic examination(s) by one or more practitioners

Remittance Advice Explanatory Code	Description
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 number of case conferences has been reached in a 12 month period
MD	Daily maximum has been exceeded
ME	Maximum number of e-assessments paid
MM	Claim does not meet requirements of the Physician Schedule of Benefits
MN	Maximum number of occipital nerve block sessions has been reached
MO	Maximum number of Optical Coherence Tomography (OCT) services has been reached
MR	Minimum service requirements have not been met
MS	Maximum allowed for sleep studies in a specific period by one or more physicians has been reached
MX	Maximum of 2 arthroscopy "R" codes with E595 has been reached
MU	Maximum Units Exceeded
MW	Maximum Number of Weeks has elapsed since payment of initial service
MY	Yearly maximum has been exceeded
O1	Fee for obstetric care apportioned
O2	Previous prenatal care already claimed

Remittance Advice Explanatory Code	Description
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
P2	Maximum fee allowed for low birth weight care
P3	Maximum fee allowed for newborn care
P4	Fee for newborn care/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
P8	Health Care Connect greater than 3 months
P9	Complex New patient
PM	Minimum roster size not met
Q7	No fee allowed for treatment of immediate family
Q8	Lab not licensed to perform this test on date of service
R1	Only one health exam allowed in a twelve-month period
R2	10 Well Baby Visits Allowed Up To Two Years Of Age
R3	One Well Child Exam (Age 2-5 Years) Allowed Within A12 Month Period

Remittance Advice Explanatory Code	Description
RD	Duplicate, paid in Reciprocal Medical Billing System (RMBS)
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
S9	Initial procedure not found
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
SF	Most Responsible Physician (MRP) visit not allowed during post-operative period-surgical fee adjusted
SN	Multiple Surgical Anaesthesia. Documentation of Separate Surgeries Same Day/Same Patient Required
SV	MRP visit not allowed during post-operative period-fee reduced to subsequent visit fee
SW	Intensive Care Unit per diem code paid to another physician-MRP subsequent visit reduced to subsequent visit

Remittance Advice Explanatory Code	Description
SX	ICU Per Diem code Paid To Another Physician, MRP Premium Not Allowed
T1	Fee allowed according to surgery claim
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 statutory holiday
V5	Only one major oculo-visual examination allowed in a 12-month period for under 19 or over 65 with medical condition; 1 in 18 month period for over 65 withouut medical condition
V6	Allowed as minor assessment-initial assessment already claimed
V7	Allowed at medical/specific re-assessment fee
V8	This service paid at lower fee as per stated OHIP policy
V9	Only one initial office visit allowed within a twelve-month period
VA	Procedure fee reduced-consultation/visit fees not allowed in addition
VB	Additional Oculo-Visual Assessment (OVA) is allowed once within the second year for patients aged 20-64, following a periodic OVA
VC	Procedure Paid Previously Not Allowed In Addition To Visit Fee. Fee Adjusted To Pay The Difference
VG	Only one geriatric general assessment premium per patient per 12-month period
VM	Oculo-visual minor assessment is only allowed within eligibility period after a major oculo-visual examination
VN	Allowed as major oculo-visual examination for seniors with medical conditions
VP	Allowed with special visit only

Remittance Advice Explanatory Code	Description
VR	Visit reduced premium not applicable
VS	Date of service was a Saturday, Sunday or statutory holiday
VT	Date of service is not a Friday, Saturday, Sunday or statutory holiday
VX	Complexity premium not applicable to visit fee
W3	Warning: - Service date is older than 3 months
W4	Warning:-service location indicator code missing
X2	Gastrointestinal (G.I.) tract includes cine and video tape
X3	Gastrointestinal (G.I.) tract includes survey film of abdomen
X4	Only one Bone Mineral Density (BMD) allowed within a 36 month period for a low risk patient
X5	Only one Bone Mineral Density (BMD) allowed within a 12 month period for a high risk patient
X6	Only one Bone Mineral Density (BMD) allowed within a 60 month period for a low risk patient

Note: These codes and their associated descriptions are subject to change.

Exemption

This technical publication has been exempted from translation under the *French Language Services Act* as per Ontario Regulation 671/92.