This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), Version 5010.

1. **Title of best practice:**

   Correct reporting of both the Claim Adjustment Group Code (CAGC) and the Claim Adjustment Reason Code (CARC) to consider the claim for payment as a secondary or tertiary payer (payer of last resort).

2. **Who does the best practice apply to:**

   Group purchasers (payers), providers

3. **Narrative description as to what is being addressed by this best practice:**

   This best practice describes how to report non-covered or not covered services on the V5010 electronic remittance advice (ASCX12/005010X221A1) Health Care Claim Payment Advice (835)).

4. **The loops, segments and elements, etc. that the best practice applies to:**

   Header Level – Loop 2100, Claim Payment Information
   - CAS01 segment, Claim Adjustment Group Code
   - CAS02 segment, Claim Adjustment Reason Code

   Line Level Loop 2110, Service Adjustment
   - CAS01 segment, Claim Adjustment Group Code
   - CAS02 segment, Claim Adjustment Reason Code
   - LQ02, Remark Code

5. **Describe how to do the best practice:**

   Claim Adjustment Group Code PR: patient responsibility

   Services or charges that are not covered or non-covered by the payer because they are not a covered under the patient's benefit plan should be reported with Claim Adjustment Group Code PR. In addition, the appropriate Claim Adjustment Reason Code indicating the services or charges are not a covered benefit should also be reported.

6. **Examples to illustrate best practice:**

   Claim Adjustment Reason Code 96: non covered charge(s)
   CAS*PR*96*100
   LQ*HE*N30
   Claim Adjustment Reason Code 204: This service/equipment/drug is not covered under the patient's current benefit plan
   CAS*PR*204*100

7. **AUC approval date: December 12, 2018**
8. **Last reviewed date: December 12, 2018**