Reason Code Quick Start Guide for HCAI

Reason codes provide anonymized and aggregated statistical information that is important to your business and the insurance industry. Choosing a reason code is an important step. Always select the most appropriate reason code for your independent decision and avoid using the 'other' code when possible.

Series	Category	Reason
Adjuster Decision	Authorization, policy limits, coverage	Authorized amount exceeded
		Authorized quantity exceeded
		Authorized time period exceeded
		Fee exceeds maximum allowed
		Good or service is not covered
		Good or service is not covered within the Minor Injury Guideline (MIG)
		Good or service is not separately reimbursable within the MIG
		Good or service requires prior authorization
		Policy coverage limits have been exhausted
		Time limit for filing has expired
		Transportation deductible has not been exceeded
	Claim settled	Expenses are not payable based on settlement agreement
	Decision update	Decision updated based on agreement by all parties
		Decision updated based on new information received
		Decision updated because of conflict of interest
		Decision updated in accordance with a binding arbitration or litigation ruling
		Decision updated in accordance with a medical opinion
	Fees and taxes	Fee exceeds reasonable fee for good or service
		Interest is incorrect or not applicable
		Tax is incorrect or not applicable
	Guidelines	Claimant is not eligible for service - see explanation
		Diagnosis indicates that the Minor Injury Guideline is appropriate
	Not reasonable and necessary	Diagnosis is inconsistent with cause of loss, procedure or provider - see explanation
		Good or service is inconsistent with the cause of loss
		Medical reason(s) - see explanation of benefits statement or correspondence with claimant
		Non-medical reason(s) - see explanation of benefits statement or correspondence with claimant

Available on HCAIinfo.ca in the HCAI Insurer User Manual *Chapter 12 : Adjuster Reason Codes*

Series	Category	Reason
Adjuster Decision	Not reasonable and necessary	Not reasonable and necessary
	Other insurance coverage	Claimant is receiving WSIB benefits
		Collateral insurance information is missing or incorrect
		Patient has other coverage (e.g. priority with other insurer)
	Withdrawn	Withdrawn on behalf of the claimant, provider or insurer - see explanation
Unable to authorize - administrative	Administrative	Billing date precedes date of service
		Date of service precedes date of loss
		Duplicate form, good or service from same provider
		Duplicate good or service from other provider
		Invoice applies to more than one plan
		Patient must claim reimbursement
		Service or procedure time adjustment
		Transferred to another provider
	Documentation, policy, claim or claimant information	Application for benefits missing or incomplete
		Does not match claimant information
		Guideline documentation required - see explanation
		No record of authorization
		Patient failed to comply with authorized procedures (e.g. examination under oath or insurer examination)
		Policy or coverage identity error
		Statement under oath not yet complete
		Statutory declaration not received
		Supporting information insufficient, incomplete or incorrect
	Waiting for opinion, ruling or agreement	Waiting for agreement by all parties
		Waiting for arbitration or litigation ruling
		Waiting for binding medical opinion
		Waiting for resolution of conflict of interest
Other	Other	Other - see explanation
Not essential	Note essential	Do not agree goods and/or services are essential