

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

*Please note: 'Organization' is defined as a Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), Prescription Drug Plan (PDP), or Cost Plan*

**The Following 100 Series Codes Pertain To Retroactive Payment Adjustment Requests  
(SCC, Medicaid & LIS Deeming Requests):**

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
100	The organization's request was completely processed.	Request was entered entirely as requested by the organization.
101	The organization's request was not processed because the beneficiary was not a member of the organization during the period requested.	Dates requested by the organization were not entered into the CMS system because, during the same period, the beneficiary was not a member of that organization.
102	This request was not processed because supporting documentation was not included with the LIS Deeming Correction; or the supporting documentation did not match the member's documentation type on the submission spreadsheet.	
104	The organization's request was partially processed because the request included months for which the beneficiary was not a member of the organization.	Only some of the dates requested by the organization were entered into the CMS system because the beneficiary was not enrolled with that organization during some of the dates requested.
105	The organization's request is a duplicate because the period requested has already been processed in the Centers for Medicare & Medicaid Services (CMS) system.	No dates requested by the organization were entered into the CMS system because the change was already in the CMS system.
106	The organization's request is a duplicate because the period requested has already been submitted by the organization.	The organization had previously requested the same change for the same beneficiary. (When this code is used, another entry for this beneficiary should be found under a different status code. In other words, Reed took some action on duplicate requests for the same beneficiary.
108	The organization did not provide sufficient information to make the requested change.	
109	The organization's Medicaid status change request was not processed because the Centers for Medicare & Medicaid Services (CMS) Third Party Master Premium Billing System (TPM) is updating the file. Please notify the state office responsible for updating TPM.	The Medicaid status information has been provided by the CMS Third Party Master Premium Billing System (TPM) and cannot be changed by any other entity. The organization should notify the state office responsible for updating the TPM about this discrepancy.
112	The organization's request was not processed because the Health Insurance Claim Number (HICN) was incorrect and the beneficiary could not be identified in the Centers for Medicare & Medicaid Services (CMS) system.	Only use this code after performing research in CMS, contacting the organization, and ascertaining that the organization cannot provide corrected information to Reed.
113	The organization's request was not processed because the beneficiary's date of death is prior to or on the first day of the requested payment month.	Use this code when the beneficiary's date of death (DOD) prevents Reed from making the requested change. (Generally, this occurs only when the DOD is the 1 <sup>st</sup> day of the month).

## Definitions of Codes on Final Disposition Reports For Retroactive Transactions

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
114	This request was not processed because award letters from the Social Security Administration (SSA) cannot be used to confirm a deemed LIS-eligibility status in CMS Systems.	
115	The organization's request was processed; however, a portion of the requested dates included dates previously requested by the organization that have already been processed in the Centers for Medicare & Medicaid Services (CMS) system.	Reed altered the dates requested in order to enter the request into Enrollment Tracking System (ETS). For example, the plan is asking for 1-1-2003 through 5-31-2003, but the MAO has previously submitted a request for 1-1-2003 through 3-31-2003.
116	The organization's Medicaid Removal request was not processed because the period to be removed is not in the Centers for Medicare & Medicaid Services (CMS) system.	Only use this code for Medicaid removal requests that cannot be processed because the Medicaid period requested to be removed does not appear in the CMS system.
117	The organization's End Stage Renal Disease (ESRD) Removal request was not processed because the period to be removed is not in the Centers for Medicare & Medicaid Services (CMS) system.	Only use this code for ESRD removal requests that cannot be processed because the ESRD period requested to be removed does not appear in the CMS system.
118	The organization's End Stage Renal Disease (ESRD) payment request was sent to the Office of Clinical Standards and Quality (OCSQ) for processing.	Reed researched the request from the organization in the CMS, REMIS, and BERT systems and determined that the Office of Clinical Standards and Quality at CMS had to update the REMIS system in order for the requested change to migrate to the CMS system.
119	The organization's request was not processed because the organization is terminated and the organization did not submit the request within the time limit allowed by the Centers for Medicare & Medicaid Services (CMS).	A request was received from an organization that is no longer effective. A terminated plan has 45 days from the date of termination to submit requests for retroactive payment adjustments. If these requests are submitted after that 45-day period, then Reed needs to verify with CMS whether Reed can process the requests. If CMS directs Reed not to process the requests, the requests are coded with this disposition code.
123	The organization's request was not processed and was sent to the Centers for Medicare & Medicaid Services (CMS) for processing since system constraints prevented the processing of the request.	Only use this code when the applicable documentation needs to be sent to CMS for processing.
125	This request was not processed as the documentation provided does not support the requested LIS level.	
128	This request was originally reported as a CMS System Error (123) and was recently reprocessed in CMS' system. Unfortunately, the request still could not be processed due to a system error. This has been reported to the CMS Help Desk and will be re-processed upon resolution.	CMS System Issue - post initial resolution
130	The request for a retroactive adjustment was cancelled. The organization requested that the initial request be disregarded.	
131	This request was not processed as the documentation provided does not support the requested start date.	

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
132	Unable to process: The request is not timely as outlined in the Retroactive Adjustment Payment Policy in the Medicare Managed Care Manual in Chapter 19, Section 60, as clarified in the letter from CMS "Timeliness of Retroactive Adjustment Submissions" dated July 15, 2005.	Use this disposition code when the requested effective date of the adjustment is beyond the 6 months of submission to Reed and no documentation has been provided to substantiate the request.
133	The organization's request was not processed because the requested effective date of the adjustment precedes the received date by six months or more, and the documentation does not substantiate the reason why the request was not submitted within the timeframes established by the Centers for Medicare & Medicaid Services (CMS). As part of the review process, the monthly attestation for the retroactive time period requested was reviewed. Since the organization filed an attestation for the period requested, all retroactive adjustment requests should have been filed within the timeframes established by CMS.	Use this code when the documentation submitted by the organization does not substantiate a valid reason why the requested change was not submitted within the time frame established by CMS.
134	The organization's request was not processed because the documentation does not meet the guidelines that are required to request a change to the applicable status category as outlined in the Standard Operating Procedures (SOP). However, the documentation submitted by the organization substantiated why the requested change was not submitted within the timeframes established by the Centers for Medicare & Medicaid Services (CMS).	Use this code when the documentation submitted by the organization substantiates why the requested change was not submitted timely, however the documentation does not meet the guidelines that are required to request a change to the applicable status category as outlined in the SOP.
135	The organization's request was not processed because the requested effective date of the adjustment precedes the received date by six months or more, and the documentation does not substantiate a valid reason the requested change was not submitted with the time frames established by the Centers for Medicare & Medicaid Services (CMS). Nor does the documentation meet the guidelines outlined in the Standard Operating Procedures (SOP) that are required to request to change to the applicable status category. As part of the review process, the monthly attestation for the retroactive time period requested reviewed. Since the organization filed an attestation for the period requested, all retroactive adjustment requests should have been filed within the timeframes established by CMS.	Use this code when the documentation submitted by the organization does not substantiate why the request was not submitted timely, nor does the documentation meet the guidelines that are required to request a change to the applicable status category as outlined in the SOP.
152	Unable to process the organization's request because the Health Insurance Claim Number (HICN) for the beneficiary listed on the spreadsheet is not for the beneficiary shown in the Centers for Medicare & Medicaid Services (CMS) systems.	

## Definitions of Codes on Final Disposition Reports For Retroactive Transactions

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
157	The organization's Low Income Subsidy (LIS) Status Correction request cannot be processed. The Centers for Medicare & Medicaid Services (CMS) systems do not reflect entitlement to Part D benefits for this beneficiary for the period requested.	
158	The organization's Low Income Subsidy (LIS) Status Correction request cannot be processed. The date requested is prior to the effective date for Part D entitlement.	
159	The organization's request for an Institutional/Nursing Home Certifiable (NHC) change was not processed. Reporting of retroactive institutional/NHC periods was allowed through December 31, 2007. No retroactive institutional processing can be accepted after that date. For additional information please contact your Account Manager at the Centers for Medicare & Medicaid Services (CMS).	
160	The organization's request cannot be processed as the beneficiary is LIS deemed at a more advantageous copayment level at the time of the request.	

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

**The Following 200 Series Codes Pertain To Retroactive Enrollment & Reinstatement Requests**

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
205	The retroactive request submitted due to plan error was processed as requested.	
210	The organization's request was completely processed because of a mistaken disenrollment by beneficiary.	A retroactive reinstatement will be approved in unique circumstances because of a mistaken disenrollment by the beneficiary.
211	The organization's retroactive enrollment request was completely processed.	A retroactive enrollment will be approved when an individual has fulfilled all election and eligibility requirements for an organization. However, the organization or CMS is unable to process the election for the statutorily required effective date.
222	The request from the organization was partially processed because the request included months in which the beneficiary was enrolled in another organization.	
226	The enrollment period requested is already in the Centers for Medicare & Medicaid Services (CMS) system. However, the Plan Benefit Package (PBP) was processed as requested.	

**The Following 300 Series Codes Pertain To Retroactive Disenrollment Requests:**

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
312	The organization's retroactive disenrollment date adjustment requested by the organization was completely processed.	

**THE FOLLOWING 400 SERIES CODE PERTAINS TO PBP CHANGES ONLY:**

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
400	The request from the organization for a retroactive Plan Benefit Package (PBP) change was completely processed.	
401	The organization's request for a Plan Benefit Package (PBP) change could not be processed as the request was for months the beneficiary was not a member of the organization.	

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

**The Following Codes Can Apply To Both Retroactive Enrollment and Retroactive Disenrollment Requests:**

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
500	The request for a retroactive change was cancelled. The organization requested that the initial request be disregarded.	
501	The organization's request for a retroactive change was not processed because the original request submitted was forwarded to your Regional Office for review and further guidance. Please contact your Account Manager for the status on this request.	
502	The organization's retroactive change request was not processed because it came from a cost-based plan that does not offer a Part D supplemental benefit.	
503	The organization's request was not processed because the documentation submitted was not conclusive. The organization's request was sent to the regional office for processing.	Request was reviewed, but the evidence provided by the organization did not substantiate the requested change to allow Reed to process the requested change. The case was submitted to the applicable Regional Office for processing.
504	The organization's request was not processed because the documentation was not complete. The request was returned to the organization for additional documentation.	Request was reviewed, but Reed did not have enough evidence to process the organization's change request. The request was returned to the organization for additional documentation.
505	The organization's request is a duplicate because the change requested by the organization has already been processed in the Centers for Medicare & Medicaid Services (CMS) system.	No action was taken on the requested change because it had already been entered into the CMS system.
506	The organization's request is a duplicate because the change requested by the organization has already been submitted by the organization.	The organization had previously requested the same change for the same beneficiary.
508	Per CMS Enrollment Guidance; retroactive enrollment and disenrollment requests must be submitted within 45 calendar days of the first reply listing or within 3 months of the effective date per February 24, 2009 HPMS memorandum on Instructions for Submitting Retroactive Enrollment & Disenrollment Activity.	
515	Processed as requested per Regional Office.	
516	Processed as requested per Central Office.	
517	Your original request was forwarded to the Regional Office for review. Based upon the review of the documentation, the Regional Office has determined that a retroactive enrollment/disenrollment change is not approved for the period requested.	
524	The retroactive disenrollment request cannot be processed. The Centers for Medicare & Medicaid Services (CMS) systems do not reflect that the beneficiary was enrolled in your organization during the period of the requested change.	Request cannot be processed as submitted, since the CMS systems do not contain enrollment information for the beneficiary to accommodate the request.

## Definitions of Codes on Final Disposition Reports For Retroactive Transactions

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
527	The retroactive request cannot be processed. Based upon the contract number submitted, the plan was not effective on the requested start date.	
529	The retroactive request cannot be processed. The beneficiary was listed on the spreadsheet submitted from the organization; however, no supporting documentation was received. The organization will need to submit the supporting documentation as outlined in Chapter 2 or the Prescription Drug Guidelines in order for the request to be considered.	
530	The retroactive request cannot be processed. The Health Insurance Claim Number (HICN) for the beneficiary listed on the spreadsheet is not for the beneficiary shown in the Centers for Medicare & Medicaid Services (CMS) systems.	
532	The retroactive request cannot be processed. The Centers for Medicare & Medicaid Services (CMS) system do not reflect entitlement to Part A/Part B/Part D benefits for this beneficiary for the period requested.	
533	The retroactive enrollment request for the period requested cannot be processed. The documentation submitted substantiates the original enrollment date. Supporting documentation to substantiate the requested reinstatement date is needed to process this request.	
536	The organization's request was not processed because the copy of the enrollment request/record must be signed by the beneficiary and received by the organization prior to the requested effective date of coverage (as defined in the CMS Enrollment guidance). Please note: The enrollment request/record must clearly indicate the receipt date.	
537	The retroactive request cannot be processed as the beneficiary is enrolled in another organization with a later application signature date.	
538	Your request could not be processed as requested. The Centers for Medicare & Medicaid Services (CMS) Central Office has determined that a retroactive enrollment/disenrollment/PBP change is not approved for the period requested.	
539	Your request could not be processed as the documentation submitted does not substantiate the requested effective date.	
541	The retroactive request submitted due to plan error cannot be processed as requested. Per the 2011 CMS Enrollment Guidance Regional Office approval is required for reinstatement due to plan error. Please contact your Regional Office Account Manager for further assistance.	
542	The retroactive request submitted due to plan error cannot be processed because a clear, detailed explanation of the plan error was not provided.	
543	The retroactive request cannot be processed because it was received by the Retroactive Processing Contractor (RPC) after the submission date required by your Regional Office Account Manager in the approval letter.	
544	The request was not processed because of discrepancies	

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
	between the information on the Submission Spreadsheet and the information on the Documentation Worksheet. A correction of the discrepancies is needed to reprocess the request. Information commonly affected would include but is not limited to: PBP number, Start Date, Beneficiary Name, and/or HICN.	
545	Documentation confirming the beneficiary understands the effect that enrollment will have on existing employer/union coverage is needed to process the request. The beneficiary's confirmation must be received no later than 30 days from the date the organization contacted the beneficiary.	
546	The cancellation request cannot be processed because written or verbal evidence that the beneficiary contacted the organization prior to the effective date of the cancellation or during the outbound verification period is needed to process the request.	
603	A copy of the signed completed enrollment record is needed to process the request. The enrollment request/record must be signed by the beneficiary and received by the organization prior to the requested effective date of coverage (as defined in the CMS Enrollment guidance). Please note: The enrollment request/record must clearly indicate the receipt date.	
605	A written statement signed by the beneficiary (or legal representative) requesting disenrollment is needed to process the request. The beneficiary's statement must be received prior to the requested effective date.	
608	A copy of the letter to the member informing him/her to continue to use plan services until the issue is resolved is needed to process the request.	
609	An active Plan Benefit Package (PBP) number is needed to process the request.	
610	Completed enrollment election form or election change form request for Plan Benefit Package (PBP) including beneficiary's signature and date is needed to process the request.	
612	The appropriate enrollment election period is needed in order to process this request. If the election period is Special Election Period (SEP), please indicate the condition that makes the beneficiary eligible for the SEP.	
613	A verbal or written statement received from the beneficiary (or legal representative) requesting to remain enrolled in the organization is needed to process the request. The beneficiary's statement must be received no later than 30 days from the date the organization sent the beneficiary a timely notice of disenrollment.	

# Definitions of Codes on Final Disposition Reports For Retroactive Transactions

THE FOLLOWING 900 SERIES CODE PERTAINS TO SEGMENT CHANGES ONLY:

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
900	The request from the organization for a retroactive Segment change was completely processed.	
901	The organization's request for a Segment change could not be processed as the request was for months the beneficiary was not a member of the organization.	