Statement

of the

American Medical Association

to the

Committee on Commerce, Science, and Transportation
United States Senate

RE: Deceptive Health Insurance Industry Practices – Are Consumers Getting What They Paid For?

Presented by Nancy H. Nielsen, MD, PhD

March 26, 2009

Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on Commerce, Science, and Transportation regarding Usual and Customary Reimbursement for Out-of-Network Providers. We commend Chairman Rockefeller, Ranking Member Hutchison, and Members of the Committee for your leadership in recognizing the far-reaching implications of the recent settlements involving the Ingenix Usual, Customary, and Reasonable (UCR) databases owned by United Health Group (United).

These databases were used for over a decade as the basis for determining the UCR fees that United and many other third-party payers paid for medical services provided out of network, that is, by physicians who had not contracted with the patient's health insurer to accept a discounted rate. These databases employed flawed data to determine out-of-network payment rates, resulting in increased health insurer profits at the expense of patients and physicians. As a result of two precedent-setting settlements entered into by United, one with the AMA and the other with Attorney General Cuomo, this practice is finally being eradicated.

The elimination of these UCR databases represents a major step toward improving the health insurance system in the United States. Most of the medical care provided pursuant to health insurance today is provided by physicians and other clinicians who have agreed to provide care to the patients covered by that health insurance product for a discount. Physicians generally try to contract with health insurers because they may receive significant benefits in return—1) a promise of prompt payment, 2) increased patient volume by virtue of inclusion in provider directories and benefit plans that give patients a substantial financial incentive to go to in-network providers, and 3) maintenance of

patient loyalty by meeting their patients' requests that they be "in-network." These benefits can justify a significant discount from a physician's retail charges.

However, at least 70 percent of people in the United States who have health insurance, have a product that covers out-of-network care for an additional premium.[1] Patients understand that not all physicians are contracted, either because the payer has restricted the network, or because the physician did not agree to the contract terms—the fee schedule offered was too low, the administrative or other burdens imposed were too high, or the health insurer was promising little or nothing with respect to benefits. Out-of-network coverage varies, but typical health insurance policies call for the insurer to pay a percentage of the UCR charge of the out-of-network provider, for example 50 percent. While health insurers have in recent years used various iterations of this language, the traditional definition of UCR charge is as follows:

- Usual: A charge is considered "usual" if it is a physician's usual charge for a procedure.
- Customary: A charge is considered "customary" if it is within a range of fees that most physicians in the area charge for a given procedure (often measured at a specific percentile of all charges submitted for a given procedure in that community).
- Reasonable: A charge is considered "reasonable" if it is usual and customary, or if it is justified because of special circumstances.

Most patients expect their physicians to bill at a rate which is typical for their specialty and community for the services provided. Thus, assuming they have health insurance which includes an out-of-network benefit of 50 percent of UCR, patients expect that if they receive a bill of $100 for a service provided by a non-contracted physician, the health insurer will pay $50 of the bill, and they will be responsible for the remainder—in this case $50. But if the insurer systematically "allows" less than the UCR charge, the patient is left with a larger bill. For example, if the payer "allows" only $80 for the $100 service, the health insurer pays $40 (50 percent of $80) and the patient is now left with a $60 obligation ($100-$40=$60).

Obviously, the size of the underpayment will vary based on the size of the claim and the way in which the insurer calculated the UCR payment, which may magnify the underpayment dramatically. For example, an insurer that bases its payment on the 50th percentile of the Ingenix database, will pay substantially less than an insurer that bases its payment on the 80th or 90th percentile. As demonstrated in several of Attorney General Cuomo's settlements, insurers that use older versions of the Ingenix database will pay less than those who are using the current database. These problems may be further compounded depending on how the benefit package is structured, particularly the deductible and coinsurance responsibilities. To the extent these are structured in a way that the patient is only "credited" with expenditures based on the understated "allowable" amount, rather than on the amount the patient has truly been responsible to pay out-of-pocket, the patient is harmed twice.

[1] 2008 Kaiser/HRET Employer Health Benefits Survey

Financial harm to the patient is not the only damage caused by this scheme. First, the patient-physician relationship may be unfairly undermined, and physicians may be unfairly defamed if patients wrongly believe they have been over-charged. As Attorney General Cuomo found in his report, "The Consumer Reimbursement System is Code Blue," states:

> The responsible consumer reads the plan documents and sees a thicket of words. One term seems intelligible: the "usual and customary rate" of a similar physician for a similar service in a similar area. That sounds reasonable. The consumer makes the leap out of network and submits the bill to the insurer, only to be told the consumer will not be fully reimbursed because the doctor's charge exceeded the usual and customary rate. The fog of ignorance continues, thanks to the insurer. The physician-patient relationship is undermined, as the physician has been branded a charlatan whose bills are inflated.

Health Care Report, "The Consumer Reimbursement System is Code Blue," State of New York, Office of the Attorney General, January 13, 2009, which can be found at, http://www.oag.state.ny.us/bureaus/health_care/HIT2/reimbursement_rates.html.

Through the Litigation Center of the AMA and the State Medical Societies, the abusive practice is being eliminated. In 2000, the AMA was joined by the Medical Society of the State of New York, the Missouri State Medical Association and several other parties in initiating a class-action lawsuit against United Health Group for using skewed data to determine out-of-network payment rates. The AMA's lawsuit alleged that the Ingenix data was artificially reduced in the following ways:

- Inadequate data ─ The Ingenix database lacks information which is relevant to a physician's retail charges, such as the physician's training and qualifications, the type of facility where the service was provided, and the patient's condition.

- Corrupted data ─ Ingenix manipulates the database in numerous ways to reduce the charges, including but not necessarily limited to all of the following:

    - by deleting valid high charges and by deleting proportionately more high charges than low charges.
    - By deleting charges that have modifiers to indicate procedures or services with complications.
    - By failing to collect information affecting the value of the service, such as whether the service was performed by someone other than a physician.
    - By pooling data from dissimilar providers (such as nurses, physician assistants, and physicians) for use in the database.
    - By maintaining outdated information.
    - By commingling negotiated or discounted rates with retail charges

- By accepting data from contributors who had already deleted higher charges from the data they submitted
- By using defective data in the database and a deficient methodology to derive charges which are artificially low. For example, if Ingenix does not have a UCR rate for a particular geographic area, it will attempt to infer or derive the rate from other geographic areas. These derived charges, however, are faulty.

- Conflict of interest ─ Last, but certainly not least, the entire enterprise was permeated with conflicts of interest. All of the insurers that contributed data to the Ingenix UCR databases had a financial motive to manipulate it in ways that reduced the UCR charges.

A detailed description of one court's findings concerning the Ingenix databases and their shortcomings is available in Judge Hochberg's thoughtful decision approving a recent class action settlement on behalf of HealthNet patients of approximately $250 million in McCoy v. HealthNet. See generally, 569 F. Supp. 2d 448 (D.N.J. 2008).

After nearly a decade of litigation, the AMA is very pleased that United Health Group recognized the importance of restoring its relationship with patients and physicians and is settling the AMA's lawsuit by agreeing to pay $350 million toward reimbursing the patients and physicians it short-changed, and by confirming in federal court its separate agreement with New York Attorney General Cuomo to end the use of this database and trust its repair and operation to a not-for-profit institution.

Indeed, evidence gathered during the course of this litigation was brought to the attention of New York Attorney General Cuomo. The AMA urged Attorney General Cuomo to investigate the abuses, and we are gratified that his office devoted such substantial resources to that effort. Attorney General Cuomo's report documenting that investigation, "Health Care Report – The Consumer Reimbursement System is Code Blue," does an excellent job of describing how the lack of transparency which characterizes the current health insurance payment system for out of network services works to disadvantage patients and their physicians, while benefiting the health insurance companies. The further specificity contained in Attorney General Cuomo's Agreements of Discontinuance with individual health insurers, which document knowing practices by certain insurers to exacerbate the problems with the Ingenix databases by using out-dated versions of those databases is especially troubling, as is the finding in his report that one national payer has been paying the same rates for in-network and out-of-network care, despite charging higher premiums for the out-of-network benefit.

The AMA commends Attorney General Cuomo for successfully negotiating the transition of the UCR database from Ingenix to an independent, not-for profit, and for his further success in gaining the commitment of virtually all of the health insurers that do business in New York to support that transition financially and with data going forward for the next five years.

Eliminating the long-standing underpayment of patients based on the faulty Ingenix database, these settlements will ensure that patients receive the benefit of the higher premiums they have paid to have out-of-network coverage. There will finally be an accurate, legitimate data warehouse compiling all physician billed charges for out-of-network services. The information from the newly created database will be available not only to payers but also to the public, including patients who are shopping for health insurance and those who are seeking medical services. This welcome transparency should go a long way toward resolving the issues with out-of-network coverage uncovered by the AMA lawsuit and confirmed by Attorney General Cuomo's investigative report and settlements.

We urge the Congress to ensure that everyone who was injured by this scheme, including federal workers who may have been shortchanged on out-of-network benefits, are provided with reasonable compensation. We also urge the Congress to pursue health insurance payment transparency. The entire health insurance payment system is marked by complexity and confusion. This is graphically illustrated by the AMA's National Health Insurer Report Card, which provides objective measures of the claims processing activities of the major health insurers. S*ee attached.* The AMA believes enormous savings would accrue to patients, physicians, health insurers, and other third-party payers if there were complete transparency. Enhancement of the Health Insurance Portability and Accountability Act (HIPAA) standard transactions by the adoption of additional standards governing payment policies and additional enforcement of the existing standards, would also lead to dramatic efficiencies throughout the system.

The AMA appreciates the opportunity to provide our views to the Committee on these critical matters affecting the nations patients and physicians and we look forward to working with the Committee and Congress to ensure accurate and transparent health insurance payments.

2008 National Health Insurer Report Card

The purpose of the AMA's National Health Insurer Report Card (NHIRC) is to provide physicians and the general public a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying these claims. Billions of dollars in administrative waste would be eliminated each year if third-party payers sent a timely, accurate and specific response to each physician claim.

The NHIRC is for informational purposes only. Physicians and payers are encouraged to review the NHIRC results and begin healing the health care claims process by supporting the AMA's "Heal the Claims Process"™ campaign and committing to the goal of reducing the cost of claims administration to 1 percent of collections. Visit the AMA Practice Management Center Web site at www.ama-assn.org/go/pmc for information on the "Heal the Claims Pprocess"™ campaign.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
Payment Timeliness								
Metric 1 Payer claim received date disclosed	100%	99.21%	0%	100%	99.76%	0.07%	99.98%	99.99%
Metric 2 First remittance response time (median days)	13	7	14	4	11	13	10	14
Metric 3 ERA activity during the data period	Not Reported (NR)	NR	NR	NR	NR	NR	NR	NR
Accuracy								
Metric 4 Allowed amount disclosed	97.77%	97.37%	19.25	99.30%	65.72%	97.33%	93.40%	98.53%
Metric 5 Contracted payment rate adherence	70.78%	72.14%	66.23%	86.74%	NR	84.20%	61.55%	98.12%
Transparency of contracted fees and payment policies on payer Web sites								
Metric 6 Contracted fee schedule	No	Yes	No	No	No	Yes	Yes	Yes
Metric 7 Contract fee schedule codes allowed per request	0	25	0	0	0	30	30	All
Metric 8 Payer-proprietary claim edits	Yes[1]	Yes[1]	Yes[1]	No[3]	Yes[1]	Yes[1]	Yes[1]	Yes
Metric 9 Medical payment policies	Yes[2]	Yes[2]	Yes[2]	No	Yes[2]	No	Yes[2]	Yes

[1] At least some payer proprietary edits are available.
[2] At least some medical payment policies are available.
[3] May not be applicable given that no payer-proprietary claim edits were identified by this analysis.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
Compliance with generally accepted pricing rules								
Metric 10 Percentage of claim lines reduced to $0 by edits	3.75%	3.40%	7.33%	0.31%	NR	3.17%	9.15%	1.40%
Metric 11* Source of payer claim edits								
CPT	1.4%	2.5%	0.6%	32.4%	NR	1.5%	4.5%	9.2%
ASA	0.0%	0.0%	0.0%	0.0%	NR	0.0%	0.0%	2.6%
NCCI	2.7%	50.4%	6.1%	50.0%	NR	9.2%	5.2%	19.0%
Medicare reimbursement policies	41.8%	31.1%	92.9%	17.6%	NR	17.3%	57.3%	49.9%
Payer-proprietary claim edits	54.1%	16.0%	0.4%	0.0%	NR	71.9%	33.0%	19.3%
Denials (Payer allows the physician's billed charge, but payment is $0)								
Metric 12 Percentages of claim lines denied	6.80%	4.62%	3.44%	2.88%	3.88%	2.90%	2.68%	6.85%

Metric 13* Reason codes (Claim adjustment reason codes [CARC]) given for denials out of 190 available reason codes.

Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
97	65.8%	16	20.1%	1	37.6%	26	53.6%	27	34.2%	27	37.9%	16	27.8%
17	7.8%	27	14.9%	B11	17.0%	109	11.5%	109	14.2%	29	17.5%	50	20.9%
1	6.8%	96	11.8%	96	13.7%	1	6.6%	B9	9.7%	1	7.9%	109	13.8%
other	19.6%	31	10.4%	18	5.7%	29	4.4%	16	9.4%	204	4.7%	96	8.5%
		204	8.9	38	5.5%	197	3.7%	96	5.9%	96	4.5%	31	5.8%
		1	7.7%	17	2.6%	160	3.1%	26	5.4%	51	3.0%	49	3.9%
		109	4.3%	other	17.8%	other	17.1%	38	4.9%	26	2.5%	other	19.3%
		29	3.7%					other	16.4%	49	2.5%		
		other	18.1%							other	19.6%		

Metric 14* Remark codes (RC) given for denials out of 675 available remark codes

Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
RC	%	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%
N19	62.4%	N197	16.1%	MA67	83.1%	N418	37.4%	N/A		N174	59.2%	N115	16.2%
N130	16.2%	N4	11.4%	other	16.9%	N130	11.0%			M86	13.1%	M25	15.0%
N102	8.5%	M81	11.3%			M127	9.2%			MA130	8.2%	N365	10.2%
other	12.9%	N225	9.7%			N179	9.2%			other	19.5%	M27	8.0%
		N155	7.3%			N59	9.2%					N286	6.0%
		N179	6.7%			N29	8.6%					N285	4.5%
		M20	5.6%			other	15.3%					N269	4.4%
		M50	5.6%									N270	4.4%
		M51	5.6%									N290	4.2%
		M64	5.6%									M15	4.0%
		other	15.1%									M16	2.8%
												other	20.2%

The AMA NHIRC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic standard transactions. The technical references for these transactions are the electronic remittance advice (ERA) (HIPAA ASC X12 835 Health Care Claim Payment/Advice Transaction) submitted to a physician in response to the receipt of an electronic claim submission (HIPAA ASC X12 837 Health Care Claim—professional transactions).

* may not total 100% due to rounding error

2008 National Health Insurer Report Card—Complete Metrics

PAYMENT TIMELINESS

Metric 1—Payer claim received date disclosed
Description: What percentage of time does the payer provide the date it received the claim (payer claim received date) in its electronic remittance advice (ERA) or explanation of benefits (EOB) response to the physician?

Metric 2—First remittance response time (median days)
Description: What is the median time period in days between the date the physician claim was received by the payer and the date the payer produced the first ERA or EOB? If a payer did not provide the payer claim received date, the most current date of service that was reported on the claim was used to perform the calculation, as noted in the disclaimer.

Metric 3—ERA activity during the data period (We have chosen not to report at this time)
Description: How many ERAs (one, two, three or more) does the physician receive for the same claim within the data period?

ACCURACY

Metric 4—Allowed amount disclosed
Description: On what percentage of records (lines on claims) does the payer provide the physician contracted rate (allowed amount) in its ERA response to the physician?

Metric 5—Contracted payment rate adherence
Description: On what percentage of records does the payer's allowed amount equal the contracted payment rate?

TRANSPARENCY OF CONTRACTED FEES AND PAYMENT POLICIES ON PAYER WEB SITES

Metric 6—Contracted fee schedule
Description: Is the physician's contracted fee schedule (payer allowed amount) available on the payer's Web site?

Metric 7—Contract fee schedule codes allowed per request
Description: If the contracted fee schedule is available on the payer's Web site, how many procedure codes are available per request?

Metric 8—Availability of payer proprietary code edits
Description: If the payer uses proprietary code edits, are they available on the payer's Web site? Proprietary code edits are edits other than those found in one or more of the following: AMA Current Procedural Terminology [1] (CPT ®), National Correct Coding Initiative (NCCI), Centers for Medicare and Medicaid Services (CMS) Publication 100-04 and the American Society of Anesthesia (ASA) Relative Value Guide.

Metric 9—Medical payment policies
Description: Are the payer's medical payment policies available on its Web site?

COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES

Metric 10—Percentage of claim lines (i.e., records) reduced by edits
Description: On what percentage of records does the payer apply a claim edit that reduces the payment (allowed amount) of the line to $0?

Metric 11—Source of claim edits
Description: On what percentage of records is the source of the claim edit applied by the payer based on one or more of the following: CPT, NCCI, CMS Publication 100-04, ASA Relative Value Guide or payer proprietary edits?

[1] CPT is a registered trademark of the American Medical Association.

DENIALS

Metric 12—Percentages of claim lines (i.e., records) denied
Description: What percentage of records submitted are denied by the payer for reasons other than a claim edit? A denial is defined as: allowed amount equal to the billed charge and the payment equals $0.

Metric 13—Reason codes (Claim Adjusted Reason Codes [CARC*]) given for denials
Description: What are the most frequently reported reason codes for a denial?

Reason Code	Description	Effective Date	Modified Date
B9	Services not covered because the patient is enrolled in a Hospice.	1/1/1995	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
1	Deductible Amount.	1/1/1995	
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	9/30/2007
18	Duplicate claim/service.	1/1/1995	
26	Expenses incurred prior to coverage.	1/1/1995	
27	Expenses incurred after coverage terminated.	1/1/1995	
29	The time limit for filing has expired.	1/1/1995	
31	Claim denied as patient cannot be identified as our insured.	1/1/1995	
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/1995	6/30/2003
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	
51	These are non-covered services because this is a pre-existing condition	1/1/1995	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1/1/1995	10/31/2006
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/1995	
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. This change to be effective 4/1/2008: Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
197	Payment adjusted for absence of precertification/ authorization.	10/31/2006	
204	This service/equipment/drug is not covered under patient's current benefit plan.	2/28/2007	

Metric 14—Remark codes given for denials
Description: What are the most frequently reported remark codes for a denial?

Remark Codes	Description	Effective Date	Modified Date
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1/1/1997	
M16	**Alert:** Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	1/1/1997	4/1/2007
M20	Missing/incomplete/invalid HCPCS.	1/1/1997	2/28/2003
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	1/1/1997	11/5/2007
M27	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	1/1/1997	8/1/2007
M50	Missing/incomplete/invalid revenue code(s).	1/1/1997	2/28/2003
M51	Missing/incomplete/invalid procedure code(s).	1/1/1997	12/2/2004
M64	Missing/incomplete/invalid other diagnosis.	1/1/1997	2/28/2003
M81	Missing/incomplete/invalid provider/supplier signature.	1/1/1997	2/28/2003
M86	Service denied because payment already made for same/similar procedure within set time frame.	1/1/1997	6/30/2003
M127	Missing patient medical record for this service.	1/1/1997	2/28/2003
MA67	Correction to a prior claim.	1/1/1997	
MA130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	1/1/1997	2/28/2003
N4	Missing/incomplete/invalid prior insurance carrier EOB.	1/1/2000	2/28/2003
N19	Procedure code incidental to primary procedure.	1/1/2000	
N29	Missing documentation/orders/notes/summary/report/chart.	1/1/2000	8/1/2005
N59	**Alert:** Please refer to your provider manual for additional program and provider information.	1/1/2000	4/1/2007
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	10/31/2001	
N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.	5/30/2002	4/1/2004
N130	Consult plan benefit documents for information about restrictions for this service.	10/31/2002	4/1/2007
N155	**Alert:** Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	10/31/2002	4/1/2007
N174	This is not a covered service/procedure/equipment/bed; however, patient liability is limited to amounts shown in the adjustments under group “PR.”	2/28/2003	
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	2/28/2003	

Remark Codes	Description	Effective Date	Modified Date
N197	The subscriber must update insurance information directly with payer.	2/25/2003	
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	8/1/2004	8/1/2005
N269	Missing/incomplete/invalid other provider name.	12/2/2004	
N270	Missing/incomplete/invalid other provider primary identifier.	12/2/2004	
N285	Missing/incomplete/invalid referring provider name.	12/2/2004	
N286	Missing/incomplete/invalid referring provider primary identifier.	12/2/2004	
N290	Missing/incomplete/invalid rendering provider primary identifier.	12/2/2004	
N365	This procedure code is not payable. It is for reporting/information purposes only.	4/1/2006	
N418	Misrouted claim. See the payer's claim submission instructions.	8/1/2007	