

Definitions of Codes on Final Disposition Reports

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

The Following 100 Series Codes Pertain To Retroactive Payment Adjustments:

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.
103	The organization's request was partially processed because the request included dates that exceeded the 36-month adjustment period allowed by the Centers for Medicare & Medicaid Services (CMS).	Only a portion of the dates requested by the organization was entered into the CMS system because some requested dates were beyond the 36-month period allowed by CMS. IntegriGuard calculates this 36-month period from the date the Regional Office and/or IntegriGuard received the original request from the organization.
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, IntegriGuard took some action on duplicate requests for the same beneficiary. This request will be entered into the duplicate table because it either is a 100% match of an earlier request or is 100% contained within an earlier request from the organization.)
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.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
110	The organization's request was completely processed; however, no payment adjustment will occur because of the payment hierarchy.	The requested change was made in the CMS system; however, it did not affect the payment because a different status category, occurring earlier in the hierarchy, is driving the payment.
111	The organization's request was not processed because the period requested exceeded the 36-month adjustment period allowed by the Centers for Medicare & Medicaid Services (CMS).	The 36-month period is calculated from the date the Regional Office and/or IntegriGuard received the original request from the organization.
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 IntegriGuard.
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 IntegriGuard from making the requested change. (Generally, this occurs only when the DOD is the 1 st day of the month).
114	The organization's Institutional 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 institutional removal requests that cannot be processed because the institutional period requested to be removed does not appear in the CMS system.
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.	IntegriGuard 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.	IntegriGuard 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.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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 IntegriGuard needs to verify with CMS whether IntegriGuard can process the requests. If CMS directs IntegriGuard not to process the requests, the requests are coded with this disposition code.
120	The organization's request was not processed because the organization did not submit the requested information.	Use this disposition code if the organization has not provided the information requested in order for IntegriGuard to process the adjustment. For example, for an SCC change, the state and county code as well as the zip code are required. If either of those pieces is missing, IntegriGuard cannot process the request in the CMS system.
121	The organization's State and County Code (SCC) request was not processed because the beneficiary address in the Centers for Medicare & Medicaid Services (CMS) system indicates a residence outside the United States. Please contact the Social Security Administration (SSA) to correct residence.	Only use this code when no prior SCC is in the CMS system for the beneficiary and the address in CMS is outside the United States. A manager must authorize use of this 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.
126	Processed as requested per request from Regional Office.	Processed as requested per request from Regional Office.
127	Processed as requested per request from Central Office.	Processed as requested per request from Central Office.
130	The request for a retroactive adjustment was cancelled. The organization requested that the initial request be disregarded.	
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 IntegriGuard and no documentation has been provided to substantiate the request.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
151	The organization's request was not processed as requested because the Health Insurance Claim Number (HICN) and beneficiary name do not match the beneficiary HICN and name in the Centers for Medicare & Medicaid Services (CMS) systems. Once the organization has corrected the information needed, please resubmit for processing.	
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.	
153	The organization's request for a 2007 Institutional/Nursing Home Certifiable (NHC) change was not processed. Since there is no demographic portion of the payment in 2007, the need for reporting Institutional/NHC ceases. Please refer to the memorandum from the Centers for Medicare & Medicaid Services (CMS) "Enrollment and Payment Processing Information for 2007" dated November 9, 2006.	
154	The organization's request for an Institutional/Nursing Home Certifiable (NHC) change was partially processed. Since there is no demographic portion of the payment in 2007, the need for reporting Institutional/NHC ceases. Therefore, only the dates prior to 2007 were processed. Please refer to the memorandum from the Centers for Medicare & Medicaid Services (CMS) "Enrollment and Payment Processing Information for 2007" dated November 9, 2006.	
155	The organization's request for an Institutional/Nursing Home Certifiable (NHC) change was not processed. Reporting of retroactive institutional periods was allowed through June 30, 2007. No retroactive institutional processing can be accepted after that date. Please refer to the memorandum from the Centers for Medicare & Medicaid Services (CMS) "Enrollment and Payment Processing Information for 2007" dated November 9, 2006.	

Definitions of Codes on Final Disposition Reports

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

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.	

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
205	The organization's request was completely processed because the initial request was not processed due to organization error.	A retroactive enrollment will be approved if the initial enrollment was not processed due to organization's error.
206	The organization's request was completely processed because the initial request was not processed due to system error.	A retroactive enrollment will be approved if the initial enrollment was not processed due to system problems or errors.
207	The organization's request was completely processed because the beneficiary cancelled his/her disenrollment request in a timely manner.	A retroactive enrollment or reinstatement will be approved if the beneficiary cancels his/her request for disenrollment from the plan before the effective date of the disenrollment.
208	The organization's request was completely processed because evidence was provided that there was an erroneous death indicator.	A retroactive enrollment or reinstatement will be approved if the beneficiary was prevented from being enrolled or was terminated from the organization in error due to an erroneous death indicator.
209	The organization's request was completely processed because evidence was provided that an erroneous loss of Medicare Part A or Part B occurred.	A retroactive enrollment or reinstatement will be approved if the beneficiary was prevented from being enrolled or was terminated from the organization in error due to an erroneous loss of Part A or Part B indicator.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.
212	The organization's retroactive enrollment request on behalf of an Employer Group Health Plan was completely processed.	An organization that has both a Medicare contract and a contract with an Employer Group Health Plan may arrange for the employer to process elections for Medicare-entitled group members. However, delays may occur between the time the beneficiary makes the election through the employer and the time the election is received by the organization. In these cases, retroactive transactions may be necessary.
213	The organization's request was completely processed because the initial request was not processed due to an incorrect Plan Benefit Package (PBP) number.	A retroactive enrollment will be approved when an individual has fulfilled all election and eligibility requirements for an organization's. However, the organization or CMS is unable to process the election for the statutorily required effective date because an incorrect PBP was submitted.
214	The organization's request was completely processed because evidence was provided that an erroneous report of End Stage Renal Disease (ESRD) occurred.	A retroactive enrollment or reinstatement will be approved when an individual has been erroneously identified as having ESRD.
215	The organization's request was completely processed because the initial request was not processed due to an incorrect Health Insurance Claim (HIC) Number.	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 because an incorrect HICN was submitted.
216	The organization's request was completely processed because evidence was provided that the beneficiary resides in the organization's service area.	A retroactive enrollment or reinstatement will be approved when an organization provides evidence that an individual is living within the service area.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
217	The organization's retroactive enrollment/Plan Benefit Package (PBP) request was processed as requested. However, it will be reported to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the acknowledgement notice/combination notice sent to the beneficiary was not sent within the timeframes outlined in the CMS guidelines.	
218	The organization's retroactive enrollment/Plan Benefit Package (PBP) request was processed as requested. However, it will be reported to CMS Regional Office that the acknowledgement notice/combination notice which is to be sent to the beneficiary within the timeframes outlined in the Centers for Medicare & Medicaid Services (CMS) guidelines was not submitted with the transaction. Please do not submit this notification now; the retroactive transaction has been processed in the CMS system. For compliance reasons, this notice should be submitted with future enrollment requests.	
219	The organization's "gap fill" enrollment/Plan Benefit Package (PBP) request has been processed as requested.	
220	The organization's retroactive enrollment date adjustment request was completely processed.	Enrollment processed for future date, however application approved for alternate date.
221	The request for reinstatement was processed due to receipt of payment from the beneficiary, who had previously been disenrolled due to nonpayment of premium.	Payment received, but not until disenroll already processed.
222	The request from the organization was partially processed because the request included months in which the beneficiary was enrolled in another organization.	
224	The request from the organization for a retroactive election type change was completely processed.	

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
225	The organization's retroactive reinstatement request was processed as requested. However, it will be reported to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the disenrollment notice sent to the beneficiary was not sent or was not sent within the timeframes outlined in the CMS guidelines. If the notification was not sent, please do not submit this notification now; as the retroactive transaction has been processed in the CMS system. For compliance reasons, this notice should be submitted with future reinstatement requests.	
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.	

Definitions of Codes on Final Disposition Reports

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

The Following 300 Series Codes Pertain To Retroactive Disenrollment Requests:

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
300	The organization's retroactive disenrollment request was completely processed because the enrollment was not legally valid.	A retroactive disenrollment will be approved if an enrollment was never legally valid as defined in subsection 40.6.
301	The organization's "gap fill" disenrollment request has been processed as requested.	
304	The organization's retroactive disenrollment request was completely processed because the initial disenrollment request from the beneficiary was not received by the organization.	A retroactive disenrollment will be approved if a disenrollment request was properly made but not processed or acted upon which includes not only system error but also organization error.
305	The organization's retroactive disenrollment request was completely processed because the initial request was received by the organization but not acted upon.	A retroactive disenrollment will be approved if a disenrollment request was properly made but not processed or acted upon.
306	The organization's retroactive disenrollment request was completely processed. The beneficiary wanted to voluntarily disenroll but was not aware that the request had to be in writing.	The organization or a beneficiary can submit a retroactive disenrollment. Requests from an organization must include supporting documentation justifying a late disenrollment.
307	The organization's retroactive disenrollment request was completely processed because the initial request was not processed due to system error.	A retroactive disenrollment will be approved if a disenrollment request was properly made but not processed or acted upon. This includes not only CMS system error but also organization error.
308	The organization's retroactive disenrollment request was completely processed because the beneficiary's cancelled enrollment was received prior to the effective date.	A retroactive disenrollment will be approved if the beneficiary cancels his/her request for enrollment in the plan before the effective date of the enrollment.
309	The organization's retroactive disenrollment request was completely processed because the beneficiary moved his/her permanent residence outside of the service area.	A retroactive disenrollment will be approved when a beneficiary's permanent residence is outside of the service area.
310	The organization's retroactive disenrollment request was completely processed because the initial request was not processed due to organization error.	A retroactive disenrollment will be approved if the initial enrollment was not processed due to organization error.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
311	The organization's retroactive disenrollment request made on behalf of an Employer Group Health Plan was completely processed.	An organization that has both a Medicare contract and a contract with an Employer Group Health Plan may arrange for the employer to process requests for disenrollment for Medicare-entitled group members. However, delays may occur between the time the beneficiary makes a request for disenrollment from the employer and the time the disenrollment is received by the organization. In these cases, retroactive transactions may be necessary.
312	The organization's retroactive disenrollment date adjustment requested by the organization was completely processed.	
317	The organization's retroactive disenrollment request was processed as requested. However, it will be reported to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the disenrollment notification sent to the beneficiary was not sent within the timeframes outlined in the CMS guidelines.	
318	The organization's retroactive disenrollment request was processed as requested. However, it will be reported to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the disenrollment notification which is to be sent to the beneficiary within the timeframes outlined in the CMS guidelines was not submitted with the transaction. Please do not submit this notification now; the retroactive transaction has been processed in the CMS system. For compliance reasons, this notice should be submitted with future disenrollment requests.	

Definitions of Codes on Final Disposition Reports

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

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.	
402	The organization's "gap fill" Plan Benefit Package (PBP) request has been processed as requested.	

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 was forwarded to the regional office for review.	
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 IntegriGuard 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 IntegriGuard did not have enough evidence to process the organization's change request. The request was returned to the organization for additional documentation.

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.
507	The retroactive transaction for an Employer Group Health Plan (EGHP) could not be processed as it exceeds the 90 day payment adjustment period.	
508	Unable to process retroactive enrollment as request was not within 45 calendar days of first reply listing.	
509	The organization's request was not processed due to system constraints. The request was sent to the Central Office for processing.	On rare occasions, an organization's request will not be able to be completed because IntegriGuard is unable to resolve or override system error messages. When this occurs, the first step is to research the issue. As a last resort, the case will be submitted to CMS Central Office for processing.
510	Unable to process the organization's request because the beneficiary died on the first day of the month and is therefore ineligible for payment.	
511	Unable to process as the organization is making a retroactive request that is the result of the organization error. Reinstatement was not recorded on a timely basis.	
512	Unable to process as the organization must provide written notification of the disenrollment within 7 days of learning of the permanent move, per section 50.2.1.4 of Chapter 2. In addition, the request was not submitted in a timely basis.	
513	Unable to process as the organization must send written notification within 20 calendar days after premiums were due, per Section 50.3.1 of Chapter 2. In addition, the request was not submitted in a timely basis.	
514	Unable to process because the organization has not submitted the requested information.	
515	Processed as requested per Regional Office.	

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.	
518	The organization's request for a retroactive disenrollment was not processed because the beneficiary was enrolled in another organization during the time of the request for disenrollment.	
520	In accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines under the Special Retroactive Clean-up Project and signed Retroactive Adjustment Attestation your organization's request could not be processed. If you have any questions regarding this, please contact your Account Manager at your Regional Office. In cases where an approval is given by the Account Manager, please resubmit the request to us along with the written approval from your Regional Office.	
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.
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.	

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.	
534	The Centers for Medicare & Medicaid Services (CMS) memorandum dated March 12, 2007 states "Plans offering Part D cannot submit any batch retro files to CMS nor retroactive enrollment, disenrollment, or Plan Benefit Package (PBP) change requests for dates in 2006 on or after March 15, 2007". Since the requested change is for 2006 and was received later than March 15, 2007, the request cannot be processed. If you have any questions regarding this, please contact your Health Insurance Specialist at CMS Central Office.	
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.	
540	The organization's request for a retroactive change was not processed per instructions from the Centers for Medicare & Medicaid Services (CMS) Central Office (CO) as 2006 is closed. Questions related to this should be addressed to your CMS Health Insurance Specialist.	

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
603	A copy of the signed completed enrollment form is needed to process the request. Please note that the applicant must have signed the form prior to the requested effective date of coverage in order to effectuate the requested effective date of coverage. If the individual is unable to sign, a legal representative must sign the request. If a legal representative signs the request for the individual, then a copy of the proof of court appointed legal guardian, durable power of attorney, or proof of other authorization required by state law that empowers the individual to effect an election on behalf of the applicant is available and can be presented upon request to the organization or CMS. This documentation is needed to process the request.	
604	Unable to process the request as the beneficiary is enrolled in another organization with a later application signature date.	
605	The beneficiary's signed written statement requesting disenrollment is needed to process the request. If the individual is unable to sign, a legal representative must sign the request. If a legal representative signs the request for the individual, then a copy of the proof of court appointed legal guardian, durable power of attorney, or proof of other authorization required by state law that empowers the individual to effect an election on behalf of the applicant is available and can be presented upon request to the organization or the Centers for Medicare & Medicaid Services (CMS). This documentation is needed to process the request.	
606	A copy of the reply listing showing the disenrollment which includes the system run date is needed to process the request.	
607	Documentation to verify the beneficiary was notified of the possible consequences related to cancelling any other coverage in order to enroll with your organization is needed to process the request.	
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.	

Definitions of Codes on Final Disposition Reports

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

CODE #	DISPOSITION CODE DESCRIPTION	DISPOSITION CODE DEFINITION
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.	
611	Tracking mechanism that provides the individual with evidence that the internet enrollment request was received (e.g. a confirmation number) 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 copy of the signed written statement from the beneficiary indicating he/she wants to remain enrolled in the organization and has not used non-plan services (except for emergency or urgently needed services) is needed to process the request.	
616	A copy of a recent reply listing which includes the system run date is needed to process the enrollment request.	
800	Resync completed.	Action to bring systems into synchronization.
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.	