**Section 2908.80 Communication Between Health Care Providers and Payers**

a) Any communication between the health care provider and the payer related to medical bill processing shall be of sufficient specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion, including, but not limited to, "payer improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position, do not satisfy the requirements of this Section.

b) The payer's utilization of the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and/or the Remittance Advice Remark Codes, or as appropriate, the NCPDP Reject/Payment Codes, specified in Section 2908.60(e)(3), when communicating with the health care provider or its agent or assignee through the use of the 835 transaction, provides a standard mechanism to communicate issues associated with the medical bill.

c) Communication between the health care provider and payer related to medical bill processing shall be made by telephone or secured electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by first class mail or personal delivery.