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Claim Adjustment Reason Codes - All

Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

1 **Deductible Amount**

Start: 01/01/1995

2 **Coinsurance Amount**

Start: 01/01/1995

3 **Co-payment Amount**

Start: 01/01/1995

4 **The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

5 **The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

6 **The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

7 **The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

8 **The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

9 **The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

10 **The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information**

REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

11 The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

12 The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

13 The date of death precedes the date of service.

Start: 01/01/1995

14 The date of birth follows the date of service.

Start: 01/01/1995

15 The authorization number is missing, invalid, or does not apply to the billed services or provider.

Start: 01/01/1995 | Last Modified: 09/30/2007

16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 01/01/1995 | Last Modified: 09/20/2009

17 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.)

Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 07/01/2009

18 Duplicate claim/service.

Start: 01/01/1995

19 This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

Start: 01/01/1995 | Last Modified: 09/30/2007

20 This injury/illness is covered by the liability carrier.

Start: 01/01/1995 | Last Modified: 09/30/2007

21 This injury/illness is the liability of the no-fault carrier.

Start: 01/01/1995 | Last Modified: 09/30/2007

22 This care may be covered by another payer per coordination of benefits.

Start: 01/01/1995 | Last Modified: 09/30/2007

23 The impact of prior payer(s) adjudication including payments and/or adjustments.

Start: 01/01/1995 | Last Modified: 09/30/2007

24 Charges are covered under a capitation agreement/managed care plan.

Start: 01/01/1995 | Last Modified: 09/30/2007

25 Payment denied. Your Stop loss deductible has not been met.

Start: 01/01/1995 | Stop: 04/01/2008

26 Expenses incurred prior to coverage.

Start: 01/01/1995

27 **Expenses incurred after coverage terminated.**

Start: 01/01/1995

28 **Coverage not in effect at the time the service was provided.**

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Redundant to codes 26&27.

29 **The time limit for filing has expired.**

Start: 01/01/1995

30 **Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.**

Start: 01/01/1995 | Stop: 02/01/2006

31 **Patient cannot be identified as our insured.**

Start: 01/01/1995 | Last Modified: 09/30/2007

32 **Our records indicate that this dependent is not an eligible dependent as defined.**

Start: 01/01/1995

33 **Insured has no dependent coverage.**

Start: 01/01/1995 | Last Modified: 09/30/2007

34 **Insured has no coverage for newborns.**

Start: 01/01/1995 | Last Modified: 09/30/2007

35 **Lifetime benefit maximum has been reached.**

Start: 01/01/1995 | Last Modified: 10/31/2002

36 **Balance does not exceed co-payment amount.**

Start: 01/01/1995 | Stop: 10/16/2003

37 **Balance does not exceed deductible.**

Start: 01/01/1995 | Stop: 10/16/2003

38 **Services not provided or authorized by designated (network/primary care) providers.**

Start: 01/01/1995 | Last Modified: 06/30/2003

39 **Services denied at the time authorization/pre-certification was requested.**

Start: 01/01/1995

40 **Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

41 **Discount agreed to in Preferred Provider contract.**

Start: 01/01/1995 | Stop: 10/16/2003

42 **Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)**

Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 06/01/2007

43 **Gramm-Rudman reduction.**

Start: 01/01/1995 | Stop: 07/01/2006

44 **Prompt-pay discount.**

Start: 01/01/1995

45 **Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).**

Start: 01/01/1995 | Last Modified: 10/31/2006

46 **This (these) service(s) is (are) not covered.**

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 96.

47 **This (these) diagnosis(es) is (are) not covered, missing, or are invalid.**

Start: 01/01/1995 | Stop: 02/01/2006

48 **This (these) procedure(s) is (are) not covered.**

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 96.

49 **These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

50 **These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

51 **These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

52 **The referring/prescribing/rendering provider is not eligible to refer/prescribe/order /perform the service billed.**

Start: 01/01/1995 | Stop: 02/01/2006

53 Services by an immediate relative or a member of the same household are not covered.

Start: 01/01/1995

54 Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

55 Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

56 Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

57 Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Split into codes 150, 151, 152, 153 and 154.

58 Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification

Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

59 Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

60 Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.

Start: 01/01/1995 | Last Modified: 06/01/2008

61 Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

62 Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 04/01/2007

63 Correction to a prior claim.

Start: 01/01/1995 | Stop: 10/16/2003

64 Denial reversed per Medical Review.

Start: 01/01/1995 | Stop: 10/16/2003

65 Procedure code was incorrect. This payment reflects the correct code.

Start: 01/01/1995 | Stop: 10/16/2003

66 Blood Deductible.

Start: 01/01/1995

67 Lifetime reserve days. (Handled in QTY, QTY01=LA)

Start: 01/01/1995 | Stop: 10/16/2003

68 DRG weight. (Handled in CLP12)

Start: 01/01/1995 | Stop: 10/16/2003

69 Day outlier amount.

Start: 01/01/1995

70 Cost outlier - Adjustment to compensate for additional costs.

Start: 01/01/1995 | Last Modified: 06/30/2001

71 Primary Payer amount.

Start: 01/01/1995 | Stop: 06/30/2000

Notes: Use code 23.

72 Coinsurance day. (Handled in QTY, QTY01=CD)

Start: 01/01/1995 | Stop: 10/16/2003

73 Administrative days.

Start: 01/01/1995 | Stop: 10/16/2003

74 Indirect Medical Education Adjustment.

Start: 01/01/1995

75 Direct Medical Education Adjustment.

Start: 01/01/1995

76 Disproportionate Share Adjustment.

Start: 01/01/1995

77 Covered days. (Handled in QTY, QTY01=CA)

Start: 01/01/1995 | Stop: 10/16/2003

78 Non-Covered days/Room charge adjustment.

Start: 01/01/1995

79 Cost Report days. (Handled in MIA15)

Start: 01/01/1995 | Stop: 10/16/2003

80 Outlier days. (Handled in QTY, QTY01=OU)

Start: 01/01/1995 | Stop: 10/16/2003

81 Discharges.

Start: 01/01/1995 | Stop: 10/16/2003

82 PIP days.

Start: 01/01/1995 | Stop: 10/16/2003

83 Total visits.

Start: 01/01/1995 | Stop: 10/16/2003

84 Capital Adjustment. (Handled in MIA)

Start: 01/01/1995 | Stop: 10/16/2003

85 Patient Interest Adjustment (Use Only Group code PR)

Start: 01/01/1995 | Last Modified: 07/09/2007

Notes: Only use when the payment of interest is the responsibility of the patient.

86 Statutory Adjustment.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Duplicative of code 45.

87 Transfer amount.

Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 01/01/2012

88 Adjustment amount represents collection against receivable created in prior overpayment.

Start: 01/01/1995 | Stop: 06/30/2007

89 Professional fees removed from charges.

Start: 01/01/1995

90 Ingredient cost adjustment. Note: To be used for pharmaceuticals only.

Start: 01/01/1995 | Last Modified: 07/01/2009

91 Dispensing fee adjustment.

Start: 01/01/1995

92 Claim Paid in full.

Start: 01/01/1995 | Stop: 10/16/2003

93 No Claim level Adjustments.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: As of 004010, CAS at the claim level is optional.

94 Processed in Excess of charges.

Start: 01/01/1995

95 Plan procedures not followed.

Start: 01/01/1995 | Last Modified: 09/30/2007

96 **Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

97 **The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

98 **The hospital must file the Medicare claim for this inpatient non-physician service.**

Start: 01/01/1995 | Stop: 10/16/2003

99 **Medicare Secondary Payer Adjustment Amount.**

Start: 01/01/1995 | Stop: 10/16/2003

100 **Payment made to patient/insured/responsible party/employer.**

Start: 01/01/1995 | Last Modified: 01/27/2008

101 **Predetermination: anticipated payment upon completion of services or claim adjudication.**

Start: 01/01/1995 | Last Modified: 02/28/1999

102 **Major Medical Adjustment.**

Start: 01/01/1995

103 Provider promotional discount (e.g., Senior citizen discount).

Start: 01/01/1995 | Last Modified: 06/30/2001

104 Managed care withholding.

Start: 01/01/1995

105 Tax withholding.

Start: 01/01/1995

106 Patient payment option/election not in effect.

Start: 01/01/1995

107 The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

108 Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

109 Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Start: 01/01/1995

110 Billing date predates service date.

Start: 01/01/1995

111 Not covered unless the provider accepts assignment.

Start: 01/01/1995

112 Service not furnished directly to the patient and/or not documented.

Start: 01/01/1995 | Last Modified: 09/30/2007

113 Payment denied because service/procedure was provided outside the United States or as a result of war.

Start: 01/01/1995 | Last Modified: 02/28/2001 | Stop: 06/30/2007

Notes: Use Codes 157, 158 or 159.

114 Procedure/product not approved by the Food and Drug Administration.

Start: 01/01/1995

115 Procedure postponed, canceled, or delayed.

Start: 01/01/1995 | Last Modified: 09/30/2007

116 The advance indemnification notice signed by the patient did not comply with requirements.

Start: 01/01/1995 | Last Modified: 09/30/2007

117 Transportation is only covered to the closest facility that can provide the necessary care.

Start: 01/01/1995 | Last Modified: 09/30/2007

118 ESRD network support adjustment.

Start: 01/01/1995 | Last Modified: 09/30/2007

119 Benefit maximum for this time period or occurrence has been reached.

Start: 01/01/1995 | Last Modified: 02/29/2004

120 Patient is covered by a managed care plan.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 24.

121 Indemnification adjustment - compensation for outstanding member responsibility.

Start: 01/01/1995 | Last Modified: 09/30/2007

122 Psychiatric reduction.

Start: 01/01/1995

123 Payer refund due to overpayment.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Refer to implementation guide for proper handling of reversals.

124 Payer refund amount - not our patient.

Start: 01/01/1995 | Last Modified: 06/30/1999 | Stop: 06/30/2007

Notes: Refer to implementation guide for proper handling of reversals.

125 Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 01/01/1995 | Last Modified: 09/20/2009

126 Deductible -- Major Medical

Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008

Notes: Use Group Code PR and code 1.

127 Coinsurance -- Major Medical

Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008

Notes: Use Group Code PR and code 2.

128 Newborn's services are covered in the mother's Allowance.

Start: 02/28/1997

129 Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 02/28/1997 | Last Modified: 01/30/2011

130 Claim submission fee.

Start: 02/28/1997 | Last Modified: 06/30/2001

131 Claim specific negotiated discount.

Start: 02/28/1997

132 Prearranged demonstration project adjustment.

Start: 02/28/1997

133 The disposition of this claim/service is pending further review.

Start: 02/28/1997 | Last Modified: 10/31/1999

134 Technical fees removed from charges.

Start: 10/31/1998

135 Interim bills cannot be processed.

Start: 10/31/1998 | Last Modified: 09/30/2007

136 Failure to follow prior payer's coverage rules. (Use Group Code OA).

Start: 10/31/1998 | Last Modified: 09/30/2007

137 Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

Start: 02/28/1999 | Last Modified: 09/30/2007

138 Appeal procedures not followed or time limits not met.

Start: 06/30/1999 | Last Modified: 09/30/2007

139 Contracted funding agreement - Subscriber is employed by the provider of services.

Start: 06/30/1999

140 Patient/Insured health identification number and name do not match.

Start: 06/30/1999

141 Claim spans eligible and ineligible periods of coverage.

Start: 06/30/1999 | Last Modified: 09/30/2007

142 Monthly Medicaid patient liability amount.

Start: 06/30/2000 | Last Modified: 09/30/2007

143 Portion of payment deferred.

Start: 02/28/2001

144 Incentive adjustment, e.g. preferred product/service.

Start: 06/30/2001

145 Premium payment withholding

Start: 06/30/2002 | Last Modified: 09/30/2007 | Stop: 04/01/2008

Notes: Use Group Code CO and code 45.

146 Diagnosis was invalid for the date(s) of service reported.

Start: 06/30/2002 | Last Modified: 09/30/2007

147 Provider contracted/negotiated rate expired or not on file.

Start: 06/30/2002

148 **Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)**

Start: 06/30/2002 | Last Modified: 09/20/2009

149 **Lifetime benefit maximum has been reached for this service/benefit category.**

Start: 10/31/2002

150 **Payer deems the information submitted does not support this level of service.**

Start: 10/31/2002 | Last Modified: 09/30/2007

151 **Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.**

Start: 10/31/2002 | Last Modified: 01/27/2008

152 **Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 10/31/2002 | Last Modified: 09/20/2009

153 **Payer deems the information submitted does not support this dosage.**

Start: 10/31/2002 | Last Modified: 09/30/2007

154 **Payer deems the information submitted does not support this day's supply.**

Start: 10/31/2002 | Last Modified: 09/30/2007

155 **Patient refused the service/procedure.**

Start: 06/30/2003 | Last Modified: 09/30/2007

156 Flexible spending account payments. Note: Use code 187.

Start: 09/30/2003 | Last Modified: 01/25/2009 | Stop: 10/01/2009

157 Service/procedure was provided as a result of an act of war.

Start: 09/30/2003 | Last Modified: 09/30/2007

158 Service/procedure was provided outside of the United States.

Start: 09/30/2003 | Last Modified: 09/30/2007

159 Service/procedure was provided as a result of terrorism.

Start: 09/30/2003 | Last Modified: 09/30/2007

160 Injury/illness was the result of an activity that is a benefit exclusion.

Start: 09/30/2003 | Last Modified: 09/30/2007

161 Provider performance bonus

Start: 02/29/2004

162 State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.

Start: 02/29/2004

163 Attachment referenced on the claim was not received.

Start: 06/30/2004 | Last Modified: 09/30/2007

164 Attachment referenced on the claim was not received in a timely fashion.

Start: 06/30/2004 | Last Modified: 09/30/2007

165 Referral absent or exceeded.

Start: 10/31/2004 | Last Modified: 09/30/2007

166 **These services were submitted after this payers responsibility for processing claims under this plan ended.**

Start: 02/28/2005

167 **This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 06/30/2005 | Last Modified: 09/20/2009

168 **Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.**

Start: 06/30/2005 | Last Modified: 09/30/2007

169 **Alternate benefit has been provided.**

Start: 06/30/2005 | Last Modified: 09/30/2007

170 **Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 06/30/2005 | Last Modified: 09/20/2009

171 **Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 06/30/2005 | Last Modified: 09/20/2009

172 **Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 06/30/2005 | Last Modified: 09/20/2009

173 Service was not prescribed by a physician.

Start: 06/30/2005 | Last Modified: 09/30/2007

174 Service was not prescribed prior to delivery.

Start: 06/30/2005 | Last Modified: 09/30/2007

175 Prescription is incomplete.

Start: 06/30/2005 | Last Modified: 09/30/2007

176 Prescription is not current.

Start: 06/30/2005 | Last Modified: 09/30/2007

177 Patient has not met the required eligibility requirements.

Start: 06/30/2005 | Last Modified: 09/30/2007

178 Patient has not met the required spend down requirements.

Start: 06/30/2005 | Last Modified: 09/30/2007

179 Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/30/2005 | Last Modified: 09/20/2009

180 Patient has not met the required residency requirements.

Start: 06/30/2005 | Last Modified: 09/30/2007

181 Procedure code was invalid on the date of service.

Start: 06/30/2005 | Last Modified: 09/30/2007

182 Procedure modifier was invalid on the date of service.

Start: 06/30/2005 | Last Modified: 09/30/2007

183 The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/30/2005 | Last Modified: 09/20/2009

184 The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/30/2005 | Last Modified: 09/20/2009

185 The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/30/2005 | Last Modified: 09/20/2009

186 Level of care change adjustment.

Start: 06/30/2005 | Last Modified: 09/30/2007

187 Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)

Start: 06/30/2005 | Last Modified: 01/25/2009

188 This product/procedure is only covered when used according to FDA recommendations.

Start: 06/30/2005

189 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed

when there is a specific procedure code for this procedure/service

Start: 06/30/2005

190 Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.

Start: 10/31/2005

191 Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)

Start: 10/31/2005 | Last Modified: 10/17/2010

192 Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.

Start: 10/31/2005 | Last Modified: 09/30/2007

193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Start: 02/28/2006 | Last Modified: 01/27/2008

194 Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.

Start: 02/28/2006 | Last Modified: 09/30/2007

195 Refund issued to an erroneous priority payer for this claim/service.

Start: 02/28/2006 | Last Modified: 09/30/2007

196 Claim/service denied based on prior payer's coverage determination.

Start: 06/30/2006 | Stop: 02/01/2007

Notes: Use code 136.

197 Precertification/authorization/notification absent.

Start: 10/31/2006 | Last Modified: 09/30/2007

198 Precertification/authorization exceeded.

Start: 10/31/2006 | Last Modified: 09/30/2007

199 Revenue code and Procedure code do not match.

Start: 10/31/2006

200 Expenses incurred during lapse in coverage

Start: 10/31/2006

201 Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR).

Start: 10/31/2006

202 Non-covered personal comfort or convenience services.

Start: 02/28/2007 | Last Modified: 09/30/2007

203 Discontinued or reduced service.

Start: 02/28/2007 | Last Modified: 09/30/2007

204 **This service/equipment/drug is not covered under the patient's current benefit plan**

Start: 02/28/2007

205 **Pharmacy discount card processing fee**

Start: 07/09/2007

206 **National Provider Identifier - missing.**

Start: 07/09/2007 | Last Modified: 09/30/2007

207 **National Provider identifier - Invalid format**

Start: 07/09/2007 | Last Modified: 06/01/2008

208 **National Provider Identifier - Not matched.**

Start: 07/09/2007 | Last Modified: 09/30/2007

209 **Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)**

Start: 07/09/2007

210 **Payment adjusted because pre-certification/authorization not received in a timely fashion**

Start: 07/09/2007

211 **National Drug Codes (NDC) not eligible for rebate, are not covered.**

Start: 07/09/2007

212 **Administrative surcharges are not covered**

Start: 11/05/2007

213 **Non-compliance with the physician self referral prohibition legislation or payer**

policy.

Start: 01/27/2008

214 Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only

Start: 01/27/2008 | Last Modified: 10/17/2010

215 Based on subrogation of a third party settlement

Start: 01/27/2008

216 Based on the findings of a review organization

Start: 01/27/2008

217 Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)

Start: 01/27/2008

218 Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation

only

Start: 01/27/2008 | Last Modified: 10/17/2010

219 Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

Start: 01/27/2008 | Last Modified: 10/17/2010

220 The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)

Start: 01/27/2008

221 Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

Start: 01/27/2008 | Last Modified: 10/17/2010

222 Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/01/2008 | Last Modified: 09/20/2009

223 Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.

Start: 06/01/2008

224 Patient identification compromised by identity theft. Identity verification required for processing this and future claims.

Start: 06/01/2008

225 Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)

Start: 06/01/2008

226 Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 09/21/2008 | Last Modified: 09/20/2009

227 Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 09/21/2008 | Last Modified: 09/20/2009

228 Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication

Start: 09/21/2008

229 Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.

Start: 01/25/2009

230 No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.

Start: 01/25/2009

231 Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 07/01/2009 | Last Modified: 09/20/2009

232 Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.

Start: 11/01/2009

233 Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.

Start: 01/24/2010

234 This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice

Remark Code that is not an ALERT.)

Start: 01/24/2010

235 Sales Tax

Start: 06/06/2010

236 This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.

Start: 01/30/2011

237 Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 06/05/2011

A0 Patient refund amount.

Start: 01/01/1995

A1 Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 01/01/1995 | Last Modified: 09/20/2009

A2 Contractual adjustment.

Start: 01/01/1995 | Last Modified: 02/28/2007 | Stop: 01/01/2008

Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.

A3 Medicare Secondary Payer liability met.

Start: 01/01/1995 | Stop: 10/16/2003

A4 Medicare Claim PPS Capital Day Outlier Amount.

Start: 01/01/1995 | Last Modified: 09/30/2007 | Stop: 04/01/2008

A5 Medicare Claim PPS Capital Cost Outlier Amount.

Start: 01/01/1995

A6 Prior hospitalization or 30 day transfer requirement not met.

Start: 01/01/1995

A7 Presumptive Payment Adjustment

Start: 01/01/1995

A8 Ungroupable DRG.

Start: 01/01/1995 | Last Modified: 09/30/2007

B1 Non-covered visits.

Start: 01/01/1995

B2 Covered visits.

Start: 01/01/1995 | Stop: 10/16/2003

B3 Covered charges.

Start: 01/01/1995 | Stop: 10/16/2003

B4 Late filing penalty.

Start: 01/01/1995

B5 Coverage/program guidelines were not met or were exceeded.

Start: 01/01/1995 | Last Modified: 09/30/2007

B6 This payment is adjusted when performed/billed by this type of provider, by this

type of provider in this type of facility, or by a provider of this specialty.

Start: 01/01/1995 | Stop: 02/01/2006

B7 **This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

B8 **Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

Start: 01/01/1995 | Last Modified: 09/20/2009

B9 **Patient is enrolled in a Hospice.**

Start: 01/01/1995 | Last Modified: 09/30/2007

B10 **Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.**

Start: 01/01/1995

B11 **The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.**

Start: 01/01/1995

B12 **Services not documented in patients' medical records.**

Start: 01/01/1995

B13 **Previously paid. Payment for this claim/service may have been provided in a previous payment.**

Start: 01/01/1995

B14 Only one visit or consultation per physician per day is covered.

Start: 01/01/1995 | Last Modified: 09/30/2007

B15 This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 09/20/2009

B16 'New Patient' qualifications were not met.

Start: 01/01/1995 | Last Modified: 09/30/2007

B17 Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Start: 01/01/1995 | Stop: 02/01/2006

B18 This procedure code and modifier were invalid on the date of service.

Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 03/01/2009

B19 Claim/service adjusted because of the finding of a Review Organization.

Start: 01/01/1995 | Stop: 10/16/2003

B20 Procedure/service was partially or fully furnished by another provider.

Start: 01/01/1995 | Last Modified: 09/30/2007

B21 The charges were reduced because the service/care was partially furnished by another physician.

Start: 01/01/1995 | Stop: 10/16/2003

B22 This payment is adjusted based on the diagnosis.

Start: 01/01/1995 | Last Modified: 02/28/2001

B23 Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.

Start: 01/01/1995 | Last Modified: 09/30/2007

D1 Claim/service denied. Level of subluxation is missing or inadequate.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D2 Claim lacks the name, strength, or dosage of the drug furnished.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D4 Claim/service does not indicate the period of time for which this will be needed.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D5 Claim/service denied. Claim lacks individual lab codes included in the test.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D6 Claim/service denied. Claim did not include patient's medical record for the service.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D7 Claim/service denied. Claim lacks date of patient's most recent physician visit.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D8 Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D10 Claim/service denied. Completed physician financial relationship form not on file.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D11 Claim lacks completed pacemaker registration form.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D13 Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D14 Claim lacks indication that plan of treatment is on file.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D15 Claim lacks indication that service was supervised or evaluated by a physician.

Start: 01/01/1995 | Stop: 10/16/2003

Notes: Use code 17.

D16 Claim lacks prior payer payment information.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 16 with appropriate claim payment remark code [N4].

D17 Claim/Service has invalid non-covered days.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 16 with appropriate claim payment remark code.

D18 Claim/Service has missing diagnosis information.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 16 with appropriate claim payment remark code.

D19 Claim/Service lacks Physician/Operative or other supporting documentation

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 16 with appropriate claim payment remark code.

D20 Claim/Service missing service/product information.

Start: 01/01/1995 | Stop: 06/30/2007

Notes: Use code 16 with appropriate claim payment remark code.

D21 This (these) diagnosis(es) is (are) missing or are invalid

Start: 01/01/1995 | Stop: 06/30/2007

D22 Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code

Start: 01/27/2008 | Stop: 01/01/2009

D23 This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Start: 11/01/2009 | Stop: 01/01/2012

W1 Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

Start: 02/29/2000 | Last Modified: 10/17/2010

W2 Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If

adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.

Start: 10/17/2010

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