Department Of Mental Health

Run Date: 11/15/2018

CIMOR Batch Provider Error Codes

Type	Code	Description
Error	B1	REJECT, No Benefit Found
Error	B2	REJECT, Account not Active
Error	B3	ALERT, Benefit is less than expected
Error	B4	ALERT, Benefit has no distribution
Error	B5	ALERT, Benefit is more than expected
Error	B6	REJECT, Consumer not found
Error	B7	REJECT, PRS Sub Account not found
Error	B8	REJECT, Account not found
Error	B9	REJECT, More than one benefit matched
Error	C1	REJECT, Account not found
Error	C2	REJECT, CAT Sub Account not found
Error	C3	REJECT, Available balance is less than SCL amount
Error	C4	REJECT, Vendor not found
Error	C5	REJECT, Account not Active
Error	C6	REJECT, Check Number not found
Error	C7	REJECT, Check Amount mismatch
Error	C8	REJECT, Check Status incorrect
Error	CB1	Used when a Debit Transaction is sent with the banking tapes and is moved into the Banking_Benefit_Tape or banking_payroll_Tape tables
Error	CB2	Used when an Empty File is received from Central Bank
Error	E1	REJECT, consumer is not assigned this program
Error	E2	REJECT, only one claim for H0001 is allowed in a 180 day period
Error	E3	REJECT, full assessment must be performed H0001
Error	E4	REJECT, consumer’s program level must be collateral dependent
Error	E5	REJECT, consumer must be designated as a collateral dependent of a primary abuser
Error	E6	REJECT, primary abuser must be entered in program
Error	E7	REJECT, needs authorization
Error	E8	REJECT, primary abuser does not have room and board service for same date of service
Error	E9	REJECT, provider needs to move consumer to Extended Program level
Error	E10	REJECT, provider needs to move consumer to Authorized Program level and authorize the additional units
Error	E11	REJECT, service is not valid for consumer’s program level
Error	E12	REJECT, maximum limit for program limit is exceeded
Error	E13	REJECT, primary abuser does not have service for same date of service
Error	E14	REJECT, nursing service only valid for Medicaid consumers
Error	E15	REJECT, cannot receive OHCDS services if in NHR
Error	E16	REJECT, Consumer must be in DD Community Support, DD Autism, or DD Residential on the date of service
Error	E17	REJECT, consumer does not have valid diagnosis for this service
Error	E18	REJECT, consumer exceeds age limit

Type	Code	Description
Error	E19	REJECT, consumer does not have valid ME code for this service
Error	E20	REJECT, service must be billed to First Steps program
Error	E21	REJECT, consumer cannot be in SCL if in waiver program
Error	E22	REJECT, service is not billed. This procedure code should be marked "non-billable" on the service matrix
Error	E23	REJECT, consumer must be in SCL program
Error	E24	REJECT. only allowed five units for ADA drug testing in a calendar week
Error	E25	REJECT, consumer is not assigned to an ADA program
Error	E26	REJECT, consumer's primary language indicates interpreting services are not needed
Error	E27	REJECT, service is not allowed for SATOP programs
Error	E28	REJECT, maximum units for program is exceeded
Error	E29	REJECT, service not allowable for program phase
Error	E30	REJECT, needs ADA SATOP Administration Group approval
Error	E31	REJECT, the service is invalid for non-treatment consumer
Error	E32	REJECT, 8 units maximum allowed in one calendar week
Error	E33	REJECT, 42 hours maximum allowed in one calendar week
Error	E34	REJECT, procedure code is in error for non-consumer specific encounter
Error	E35	REJECT, procedure code is invalid for non-consumer specific category
Error	E36	REJECT, consumer must be in NHR program
Error	E37	REJECT, cannot enter services for this service category
Error	E38	REJECT, procedure code not valid for Rehabilitation program level
Error	E39	REJECT, service not allowed for Intensive program level
Error	E40	REJECT, service not allowed for Maintenance program level
Error	E41	REJECT, consumer is not assigned to a CPS program with pay-to provider
Error	E42	REJECT, consumer is not assigned to CPS Youth Children’s System of Care program in the same EOC
Error	E43	REJECT, consumer is not assigned to a CPS program in the same EOC
Error	E44	REJECT, consumer is not assigned to both ADA and CPS program in the same EOC
Error	E45	REJECT, case note must be entered
Error	E46	REJECT, 8 hours maximum for one day
Error	E47	REJECT, procedure code invalid for consumer’s assigned program
Error	E48	REJECT, service category is in error on the service matrix
Error	E49	REJECT, needs to be entered under the CPR service category to bill to Medicaid
Error	E50	REJECT, Rehabilitation & Maintenance are the only 2 program levels for CPR
Error	E51	REJECT, Not a valid procedure code for Medication Administration
Error	E52	REJECT, cannot bill to these service categories for inpatient
Error	E53	REJECT, service is not billable to Medicaid
Error	E54	REJECT, Only 2 units of ADA Drug Testing per consumer per 30 days (month)
Error	E55	ENCOUNTER DENIED, diagnosis does not exist for both ADA and CPS

Type	Code	Description
Error	E56	ENCOUNTER DENIED, consumer is not assigned to a CPS Adult Program
Error	E57	ENCOUNTER DENIED, consumer is not assigned to a CPS Program
Error	E58	ENCOUNTER DENIED, consumer is not assigned to a CPS Youth Children's System of Care
Error	E59	ENCOUNTER DENIED, consumer is not assigned to a CPS Youth Program
Error	E60	ENCOUNTER DENIED, consumer is not assigned to this program
Error	E61	ENCOUNTER DENIED, procedure code not valid for program level
Error	E62	ENCOUNTER DENIED, program level not defined
Error	E63	ENCOUNTER DENIED, service must be non-consumer specific
Error	E64	ENCOUNTER DENIED, service must be authorized
Error	E65	REJECT, only one intake evaluation allowed in the last 355 days
Error	E66	REJECT, cannot receive more than 6 hours of service in a day
Error	E67	REJECT, cannot receive more than 8 hours of service in a day
Error	E68	REJECT, cannot receive OHCDS service if in Nursing Home Reform
Error	E69	REJECT, consumer cannot be in DD Residential if in Waiver Program
Error	E71	ENCOUNTER DENIED, cannot receive Cases Management if in Nursing Home Reform.
Error	E72	ENCOUNTER DENIED, cannot receive Cases Management if in Intake & Assessment
Error	E73	REJECT, Not valid for non-Medicaid Consumer
Error	E74	REJECT, consumer cannot have MC+ eligibility and have a waiver slot
Error	E75	REJECT, service only valid for non-Medicaid consumer
Error	E76	REJECT, Encounter Funds and SAMII Adjustments have different expended indicator
Error	E77	REJECT, Contract Service is expired
Error	E78	REJECT, consumer is not Medicaid Eligible
Error	E79	REJECT, service has a negative dollar amount
Error	E80	REJECT, claim already exists and is no longer open
Error	E81	REJECT, error applying SMT (Consumer has no or overlapping SMT).
Error	E82	Reject, Service Amount is greater than Medicaid amount
Error	E83	REJECT, consumer must be in program level "Collateral Dependant"
Error	E84	REJECT, Admission referral must be from Department of Corrections
Error	E85	REJECT, allocation does not have enough funds to pre-encumber
Error	E86	REJECT, Provider must be a Medicaid Provider
Error	E87	REJECT, Consumer does not have a waiver slot
Error	E88	REJECT, this service category is invalid for the consumer program assignment
Error	E89	REJECT, cannot receive DD Purchase of Service if in Nursing Home Reform
Error	E90	REJECT, DOC ID has not been entered on Admission
Error	E91	Reject, Cannot process because the Consumer marked as duplicate
Error	E92	REJECT, Consumer not in ATR3 program
Error	E93	REJECT, Encounter does not have any diagnosis.

Type	Code	Description
Error	E99	REJECT, invalid claim structure
Error	H1	HOLD, When Intake and Assessment program is ended the system will set the status back to Ready to Process
Error	H2	HOLD, Holding to bill Commerical Insurance
Error	H3	HOLD, Holding to bill Medicare Claims
Error	I1	INFORMATION, encounter is being resubmited due to a processing problem
Error	ICM1	ICM READY, Service is Medicare Part A billable.
Error	ICM10	ICM REJECT, Services paid on previously submitted claim.
Error	ICM2	ICM REJECT, Consumer is not in a Medicare certified bed.
Error	ICM3	ICM REJECT, Consumer is not Medicare Part A eligible.
Error	ICM4	ICM REJECT, Consumer has commercial insurance as primary.
Error	ICM5	ICM REJECT, Not an institutional service.
Error	ICM6	ICM HOLD, First Medicare Part A claim is pending.
Error	ICM7	ICM HOLD, Subsequent Medicare Part A claim is pending.
Error	ICM8	ICM ACCEPT, First Medicare Part A claim.
Error	ICM9	ICM ACCEPT, Subsequent Medicare Part A claim.
Error	M1	REJECT, Invalid Consumer ID
Error	M2	REJECT, Invalid Birth Date
Error	M3	REJECT, Invalid Gender Code
Error	M4	REJECT, Invalid Diagnosis Code
Error	M5	REJECT, Invalid Procedure Code
Error	M6	REJECT, Invalid Modifier Code
Error	M7	REJECT, Invalid Date(s) of Service
Error	M8	REJECT, Units of Service must be a valid non-negative whole number
Error	M9	REJECT, Dollar Amount must be a valid non-negative numeric value
Error	M10	REJECT, Missing or Invalid Medication Code
Error	M11	REJECT, Missing or Invalid Rendering Provider
Error	M12	REJECT, Invalid Location Code
Error	M13	REJECT, Consumer ID has been marked as Duplicate. Use alternate ID
Error	M14	REJECT, Consumer ID, Gender and Birth Date do not match any consumer records
Error	M15	REJECT, Consumer does not have an episode of care with the provider on the date of service
Error	M16	REJECT, Consumer was not assigned to a program on date of service
Error	M17	REJECT, Invalid contract number. Providers do not match
Error	M18	REJECT, Contract is not available for use
Error	M19	REJECT, Service not found on contract
Error	M20	REJECT, Location not valid for service delivered
Error	M21	REJECT, Date of Service cannot be future date
Error	M22	REJECT, Invalid Contract Number

Type	Code	Description
Error	M23	REJECT, Consumer has no SMT for date of service
Error	M24	REJECT, Procedure code requires valid Medication
Error	M25	REJECT, Procedure code requires valid Rendering Provider
Error	M26	REJECT, Entered dollar amount cannot be greater than contract amount
Error	M27	REJECT, Invalid Modifier Code Sequence
Error	M28	REJECT, Adjustment reason required when billing less than the contract amount
Error	M29	REJECT, Service date range must be within the same calendar month
Error	M30	Reject, Rendering Provider ID is marked as a duplicate in CIMOR. Please use alternate ID.
Error	M31	Reject, Procedure Code is Non-Consumer specific.
Error	M32	Reject, Practitioner not in the required HR group.
Error	M33	REJECT, Other cannot be entered as a Medication unless the "Drug List Override" is checked on the Admission page.
Error	P1	PROCESS ERROR, can not determine post rules task
Error	P2	PROCESS ERROR, cannot determine provider allocation
Error	P3	PROCESS ERROR, error applying SMT
Error	P4	PROCESS ERROR, error encumbering funds
Error	P5	PROCESS ERROR, error loading encounter to 837
Error	P6	PROCESS ERROR, error saving claims dataset in 837 load
Error	P7	PROCESS ERROR, bad SAM II Encounter row
Error	P8	PROCESS ERROR, error getting SAM II Invoice from data base
Error	P9	PROCESS ERROR, no rules fired
Error	P10	PROCESS ERROR, Consumer Program not found
Error	P12	PROCESS ERROR, more than one provider allocation was found
Error	P13	PROCESS ERROR, Provider not found
Error	P14	PROCESS ERROR, Service Category not found
Error	P15	PROCESS ERROR, Consumer not in EOC
Error	P16	PROCESS ERROR, directory type not recognized
Error	P17	PROCESS ERROR, inbound or outbound directory not found
Error	P18	PROCESS ERROR, archive directory not found
Error	P19	PROCESS ERROR, security exception opening inbound file
Error	P20	PROCESS ERROR,general exception opening inbound file
Error	P21	PROCESS ERROR, file with same MD5 code already in database
Error	P22	PROCESS ERROR, security exception copying file to archive directory
Error	P23	PROCESS ERROR, pathTooLongException exception copying file to archive directory
Error	P24	PROCESS ERROR, IOException exception copying file to archive directory
Error	P25	PROCESS ERROR, general exception copying file to archive directory
Error	P26	PROCESS ERROR, security exception deleting file from inbound directory
Error	P27	PROCESS ERROR, general exception deleting file from inbound directory

Type	Code	Description
Error	P28	PROCESS ERROR, file already exists on outbound directory
Error	P29	PROCESS ERROR, security exception creating outbound file
Error	P30	PROCESS ERROR, general exception creating outbound file
Error	P32	PROCESS ERROR, Attending Physician missing
Error	P33	PROCESS ERROR, published code not found
Error	P34	PROCESS ERROR, can not write message to database
Error	P35	PROCESS ERROR, can not write message to message queue
Error	P36	PROCESS ERROR, duplicate Org ID value
Error	P37	PROCESS ERROR, Diagnosis missing
Error	P38	PROCESS ERROR, Service Category missing
Error	P39	PROCESS ERROR, Bed Count cannot be zero
Error	P40	PROCESS ERROR, Service Matrix row not found
Error	P41	PROCESS ERROR, facility code not found in directory structure
Error	P42	PROCESS ERROR, valid facility code not in directory structure
Error	P43	PROCESS ERROR, recieve directory not found in MSMQ label
Error	P44	PROCESS ERROR, "in" sub-directory not found it receive directory path
Error	P45	PROCESS ERROR, could not create encounter from inbound 837
Error	P46	PROCESS ERROR, could not create claim confirmation
Error	P47	PROCESS ERROR, additional 835 received.
Error	P48	PROCESS ERROR, Bed Assignment Dates invalid
Error	P49	PROCESS ERROR, OHCDS Allocation ID missing
Error	P50	PROCESS ERROR, FFP Adjustment with zero paid amount
Error	P51	PROCESS ERROR, the Division Code for the Encounter is missing
Error	P52	PROCESS ERROR, there was an error
Error	P53	PROCESS ERROR, void rejected by payer
Error	P54	PROCESS ERROR, SMT missing for Bed Encounter
Error	P55	WARNING MESSAGE, Multiple Encounters for the same day on the same Episode Of Care
Error	P56	PROCESS ERROR, Consumer is Deceased
Error	P103	PROCESS ERROR, error applying SATOP fee
Error	P104	PROCESS ERROR, can not load void\rebill
Error	P105	PROCESS ERROR, can not process RA. See task comment for reason
Error	P106	Process Error - Could not update Preencumber data
Error	P999	PROCESS ERROR, general exception. See related logs for details
Error	R1	REJECT, Account not found
Error	R2	REJECT, CAT Sub Account not found
Error	R3	REJECT, Available balance is less than Inpatient amount
Error	R4	REJECT, Vendor not found

Type	Code	Description
Error	R5	REJECT, Account not Active
Error	S1	REJECT, Account not found for DCN
Error	S2	REJECT, CAT Sub Account not found for DCN
Error	S3	REJECT, Available balance is less than spend down amount
Error	S4	REJECT, Vendor not found
Error	S5	REJECT, Account not Active
Remark	19	19
Remark	65	65
Remark	AD	AD
Remark	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
Remark	M2	Not paid separately when the patient is an inpatient.
Remark	M3	Equipment is the same or similar to equipment already being used.
Remark	M4	Alert: This is the last monthly installment payment for this durable medical equipment. (Modified 4/1/07)
Remark	M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
Remark	M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. (Modified 4/1/07, 3/1/2009)
Remark	M7	No rental payments after the item is purchased, returned or after the total of issued rental payments equals the purchase price. (Modified 11/1/2016)
Remark	M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
Remark	M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement. (Modified 4/1/07)
Remark	M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
Remark	M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
Remark	M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
Remark	M13	Only one initial visit is covered per specialty per medical group. (Modified 6/30/03)
Remark	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
Remark	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Remark	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. (Reactivated 4/1/04, Modified 11/18/05, 4/1/07)
Remark	M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. (Modified 4/1/07)
Remark	M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home. (Modified 6/30/03)
Remark	M19	Missing oxygen certification/re-certification. (Modified 2/28/03) Related to N234
Remark	M20	Missing/incomplete/invalid HCPCS. (Modified 2/28/03)
Remark	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home. (Modified 2/28/03)
Remark	M22	Missing/incomplete/invalid number of miles traveled. (Modified 2/28/03)
Remark	M23	Missing invoice. (Modified 8/1/05)

Type	Code	Description
Remark	M24	Missing/incomplete/invalid number of doses per vial. (Modified 2/28/03)
Remark	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. (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)
Remark	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
Remark	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. (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)
Remark	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
Remark	M29	Missing operative note/report. (Modified 2/28/03, 7/1/2008) Related to N233
Remark	M30	Missing pathology report. (Modified 8/1/04, 2/28/03) Related to N236
Remark	M31	Missing radiology report. (Modified 8/1/04, 2/28/03) Related to N240
Remark	M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service. (Modified 4/1/07)
Remark	M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider. Consider using M68
Remark	M34	Claim lacks the CLIA certification number. Consider using MA120
Remark	M35	Missing/incomplete/invalid pre-operative photos or visual field results. Consider using N178
Remark	M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
Remark	M37	Not covered when the patient is under age 35. (Modified 3/8/11)
Remark	M38	Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges. (Modified 7/1/15)
Remark	M39	Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements. (Modified 2/1/04, 4/1/07, 11/1/09, 11/1/12, 7/1/15) Related to N563
Remark	M40	Claim must be assigned and must be filed by the practitioner's employer.
Remark	M41	We do not pay for this as the patient has no legal obligation to pay for this.
Remark	M42	The medical necessity form must be personally signed by the attending physician.
Remark	M43	Payment for this service previously issued to you or another provider by another carrier/intermediary. Consider using Reason Code 23
Remark	M44	Missing/incomplete/invalid condition code. (Modified 2/28/03)

Type	Code	Description
Remark	M45	Missing/incomplete/invalid occurrence code(s). (Modified 12/2/04) Related to N299
Remark	M46	Missing/incomplete/invalid occurrence span code(s). (Modified 12/2/04) Related to N300
Remark	M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN). (Modified 2/28/03, 7/1/15)
Remark	M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service. Consider using M97
Remark	M49	Missing/incomplete/invalid value code(s) or amount(s). (Modified 2/28/03)
Remark	M50	Missing/incomplete/invalid revenue code(s). (Modified 2/28/03)
Remark	M51	Missing/incomplete/invalid procedure code(s). (Modified 12/2/04) Related to N301
Remark	M52	Missing/incomplete/invalid “from” date(s) of service. (Modified 2/28/03)
Remark	M53	Missing/incomplete/invalid days or units of service. (Modified 2/28/03)
Remark	M54	Missing/incomplete/invalid total charges. (Modified 2/28/03)
Remark	M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
Remark	M56	Missing/incomplete/invalid payer identifier. (Modified 2/28/03)
Remark	M57	Missing/incomplete/invalid provider identifier.
Remark	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
Remark	M59	Missing/incomplete/invalid “to” date(s) of service. (Modified 2/28/03)
Remark	M60	Missing Certificate of Medical Necessity. (Modified 8/1/04, 6/30/03) Related to N227
Remark	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
Remark	M62	Missing/incomplete/invalid treatment authorization code. (Modified 2/28/03)
Remark	M63	We do not pay for more than one of these on the same day. Consider using M86
Remark	M64	Missing/incomplete/invalid other diagnosis. (Modified 2/28/03)
Remark	M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
Remark	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
Remark	M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302
Remark	M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
Remark	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code. (Modified 2/1/04)
Remark	M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item. (Modified 4/1/2007, 8/1/07)
Remark	M71	Total payment reduced due to overlap of tests billed.
Remark	M72	Did not enter full 8-digit date (MM/DD/CCYY). Consider using MA52
Remark	M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. (Modified 8/1/04)
Remark	M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment. (Modified 12/2/04)
Remark	M75	Multiple automated multichannel tests performed on the same day combined for payment. (Modified 11/5/07)
Remark	M76	Missing/incomplete/invalid diagnosis or condition. (Modified 2/28/03)

Type	Code	Description
Remark	M77	Missing/incomplete/invalid/inappropriate place of service. (Modified 2/28/03, 3/1/2014, 3/14/2014)
Remark	M78	Missing/incomplete/invalid HCPCS modifier. (Modified 2/28/03,) Consider using Reason Code 4
Remark	M79	Missing/incomplete/invalid charge. (Modified 2/28/03)
Remark	M80	Not covered when performed during the same session/date as a previously processed service for the patient. (Modified 10/31/02)
Remark	M81	You are required to code to the highest level of specificity. (Modified 2/1/04)
Remark	M82	Service is not covered when patient is under age 50.
Remark	M83	Service is not covered unless the patient is classified as at high risk.
Remark	M84	Medical code sets used must be the codes in effect at the time of service. (Modified 2/1/04, 3/14/2014)
Remark	M85	Subjected to review of physician evaluation and management services.
Remark	M86	Service denied because payment already made for same/similar procedure within set time frame. (Modified 6/30/03)
Remark	M87	Claim/service(s) subjected to CFO-CAP prepayment review.
Remark	M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work. Consider using Reason Code B20
Remark	M89	Not covered more than once under age 40.
Remark	M90	Not covered more than once in a 12 month period.
Remark	M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
Remark	M92	Services subjected to review under the Home Health Medical Review Initiative.
Remark	M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
Remark	M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
Remark	M95	Services subjected to Home Health Initiative medical review/cost report audit.
Remark	M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
Remark	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
Remark	M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN. Consider using M99
Remark	M99	Missing/incomplete/invalid Universal Product Number/Serial Number. (Modified 2/28/03)
Remark	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
Remark	M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier. Consider using M78
Remark	M102	Service not performed on equipment approved by the FDA for this purpose.
Remark	M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
Remark	M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
Remark	M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
Remark	M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service. Consider using MA 31

Type	Code	Description
Remark	M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
Remark	M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
Remark	M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
Remark	M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
Remark	M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
Remark	M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides. (Modified 11/5/07)
Remark	M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program. (Modified 11/5/07)
Remark	M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. (Modified 8/1/06, 11/5/07)
Remark	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier. (Modified 11/5/2007)
Remark	M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program. (Modified 2/1/04, 3/15/11)
Remark	M117	Not covered unless submitted via electronic claim. (Modified 6/30/03)
Remark	M118	Letter to follow containing further information. Consider using N202
Remark	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). (Modified 2/28/03, 4/1/04)
Remark	M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
Remark	M121	We pay for this service only when performed with a covered cryosurgical ablation.
Remark	M122	Missing/incomplete/invalid level of subluxation. (Modified 2/28/03)
Remark	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. (Modified 2/28/03)
Remark	M124	Missing indication of whether the patient owns the equipment that requires the part or supply. (Modified 2/28/03) Related to N230
Remark	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed. (Modified 2/28/03)
Remark	M126	Missing/incomplete/invalid individual lab codes included in the test. (Modified 2/28/03)
Remark	M127	Missing patient medical record for this service. (Modified 2/28/03) Related to N237
Remark	M128	Missing/incomplete/invalid date of the patient’s last physician visit.
Remark	M129	Missing/incomplete/invalid indicator of x-ray availability for review. (Modified 2/28/03, 6/30/03)
Remark	M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used. (Modified 2/28/03) Related to N231
Remark	M131	Missing physician financial relationship form. (Modified 2/28/03) Related to N239
Remark	M132	Missing pacemaker registration form. (Modified 2/28/03) Related to N235
Remark	M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
Remark	M134	Performed by a facility/supplier in which the provider has a financial interest. (Modified 6/30/03)
Remark	M135	Missing/incomplete/invalid plan of treatment. (Modified 2/28/03)
Remark	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician. (Modified 2/28/03)
Remark	M137	Part B coinsurance under a demonstration project or pilot program. (Modified 11/1/12)

Type	Code	Description
Remark	M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
Remark	M139	Denied services exceed the coverage limit for the demonstration.
Remark	M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday Consider using M82
Remark	M141	Missing physician certified plan of care. (Modified 2/28/03) Related to N238
Remark	M142	Missing American Diabetes Association Certificate of Recognition. (Modified 2/28/03) Related to N226
Remark	M143	The provider must update license information with the payer. (Modified 12/1/06)
Remark	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
Remark	MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)
Remark	MA02	Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. (Modified 10/31/02, 6/30/03, 8/1/05, 12/29/05, 8/1/06, 4/1/07)
Remark	MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time. Consider using MA02 (Modified 10/31/02, 6/30/03, 8/1/05, 11/18/05)
Remark	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
Remark	MA05	Incorrect admission date patient status or type of bill entry on claim. Consider using MA30, MA40 or MA43
Remark	MA06	Missing/incomplete/invalid beginning and/or ending date(s). Consider using MA31
Remark	MA07	Alert: The claim information has also been forwarded to Medicaid for review. (Modified 4/1/07)
Remark	MA08	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare. (Modified 4/1/07)
Remark	MA09	Alert: Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement. (Modified 11/1/2014, 11/1/2015)
Remark	MA10	Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient. (Modified 4/1/07)
Remark	MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources. Consider using M32
Remark	MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
Remark	MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code. (Modified 4/1/07)
Remark	MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services. (Modified 4/1/07, 8/1/07)
Remark	MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (Modified 4/1/07)
Remark	MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
Remark	MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

Type	Code	Description
Remark	MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them. (Modified 4/1/07)
Remark	MA19	Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer. (Modified 4/1/07)
Remark	MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence. (Modified 6/30/03)
Remark	MA21	SSA records indicate mismatch with name and sex.
Remark	MA22	Payment of less than $1.00 suppressed.
Remark	MA23	Demand bill approved as result of medical review.
Remark	MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period. (Modified 6/30/03)
Remark	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
Remark	MA26	Alert: Our records indicate that you were previously informed of this rule. (Modified 4/1/07)
Remark	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim. (Modified 2/28/03)
Remark	MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice. (Modified 4/1/07)
Remark	MA29	Missing/incomplete/invalid provider name, city, state, or zip code.
Remark	MA30	Missing/incomplete/invalid type of bill. (Modified 2/28/03)
Remark	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. (Modified 2/28/03)
Remark	MA32	Missing/incomplete/invalid number of covered days during the billing period. (Modified 2/28/03)
Remark	MA33	Missing/incomplete/invalid noncovered days during the billing period. (Modified 2/28/03)
Remark	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period. (Modified 2/28/03)
Remark	MA35	Missing/incomplete/invalid number of lifetime reserve days. (Modified 2/28/03)
Remark	MA36	Missing/incomplete/invalid patient name. (Modified 2/28/03)
Remark	MA37	Missing/incomplete/invalid patient's address. (Modified 2/28/03)
Remark	MA38	Missing/incomplete/invalid birth date.
Remark	MA39	Missing/incomplete/invalid gender. (Modified 2/28/03)
Remark	MA40	Missing/incomplete/invalid admission date. (Modified 2/28/03)
Remark	MA41	Missing/incomplete/invalid admission type. (Modified 2/28/03)
Remark	MA42	Missing/incomplete/invalid admission source. (Modified 2/28/03)
Remark	MA43	Missing/incomplete/invalid patient status. (Modified 2/28/03)
Remark	MA44	Alert: No appeal rights. Adjudicative decision based on law. (Modified 4/1/07)
Remark	MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account. (Modified 4/1/07)
Remark	MA46	Alert: The new information was considered but additional payment will not be issued. (Modified 3/1/2009, 11/1/2015)
Remark	MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
Remark	MA48	Missing/incomplete/invalid name or address of responsible party or primary payer. (Modified 2/28/03)
Remark	MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services. Consider using MA76

Type	Code	Description
Remark	MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. (Modified 2/28/03, 3/1/2014)
Remark	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory. Consider using MA120
Remark	MA52	Missing/incomplete/invalid date.
Remark	MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification. (Modified 2/1/04)
Remark	MA54	Physician certification or election consent for hospice care not received timely.
Remark	MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
Remark	MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
Remark	MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
Remark	MA58	Missing/incomplete/invalid release of information indicator. (Modified 2/28/03)
Remark	MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice. (Modified 4/1/07)
Remark	MA60	Missing/incomplete/invalid patient relationship to insured. (Modified 2/28/03)
Remark	MA61	Missing/incomplete/invalid social security number. (Modified 2/28/03, 3/1/2018)
Remark	MA62	Alert: This is a telephone review decision. (Modified 4/1/07, 8/1/07)
Remark	MA63	Missing/incomplete/invalid principal diagnosis. (Modified 2/28/03)
Remark	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
Remark	MA65	Missing/incomplete/invalid admitting diagnosis. (Modified 2/28/03)
Remark	MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303
Remark	MA67	Alert: Correction to a prior claim. (Modified 11/1/2015)
Remark	MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim. (Modified 4/1/07)
Remark	MA69	Missing/incomplete/invalid remarks. (Modified 2/28/03)
Remark	MA70	Missing/incomplete/invalid provider representative signature. (Modified 2/28/03)
Remark	MA71	Missing/incomplete/invalid provider representative signature date. (Modified 2/28/03)
Remark	MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice. (Modified 4/1/07)
Remark	MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
Remark	MA74	Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned. (Modified 7/1/15)
Remark	MA75	Missing/incomplete/invalid patient or authorized representative signature. (Modified 2/28/03)
Remark	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services. (Modified 2/28/03, 2/1/04)
Remark	MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice. (Modified 4/1/07)

Type	Code	Description
Remark	MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient. Consider using MA59
Remark	MA79	Billed in excess of interim rate.
Remark	MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
Remark	MA81	Missing/incomplete/invalid provider/supplier signature. (Modified 2/28/03)
Remark	MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
Remark	MA83	Did not indicate whether we are the primary or secondary payer. (Modified 8/1/05)
Remark	MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
Remark	MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective. Consider using MA92
Remark	MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage. Consider using MA92
Remark	MA87	Missing/incomplete/invalid insured's name for the primary payer. Consider using MA92
Remark	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer. (Modified 2/28/03)
Remark	MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer. (Modified 2/28/03)
Remark	MA90	Missing/incomplete/invalid employment status code for the primary insured. (Modified 2/28/03).
Remark	MA91	Alert: This determination is the result of the appeal you filed. (Modified 7/1/15)
Remark	MA92	Missing plan information for other insurance. (Modified 2/1/04) Related to N245
Remark	MA93	Non-PIP (Periodic Interim Payment) claim. (Modified 6/30/03)
Remark	MA94	Did not enter the statement “Attending physician not hospice employee” on the claim form to certify that the rendering physician is not an employee of the hospice. (Reactivated 4/1/04, Modified 8/1/05)
Remark	MA95	A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500. (Deactivated 2/28/2003) (Erroneous description corrected 9/2/2008) Consider using M51
Remark	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
Remark	MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number. (Modified 2/29/08)
Remark	MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary. Consider using MA97
Remark	MA99	Missing/incomplete/invalid Medigap information. (Modified 2/28/03)
Remark	MA100	Missing/incomplete/invalid date of current illness or symptoms. (Modified 2/28/03, 3/30/05, 3/14/2014)
Remark	MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. Consider using N538
Remark	MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider. Consider using M68
Remark	MA103	Hemophilia Add On.
Remark	MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician. Consider using M128 or M57
Remark	MA105	Missing/incomplete/invalid provider number for this place of service.
Remark	MA106	PIP (Periodic Interim Payment) claim. (Modified 6/30/03)

Type	Code	Description
Remark	MA107	Paper claim contains more than three separate data items in field 19.
Remark	MA108	Paper claim contains more than one data item in field 23.
Remark	MA109	Claim processed in accordance with ambulatory surgical guidelines.
Remark	MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim. (Modified 2/28/03)
Remark	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address. (Modified 2/28/03)
Remark	MA112	Missing/incomplete/invalid group practice information. (Modified 2/28/03)
Remark	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
Remark	MA114	Missing/incomplete/invalid information on where the services were furnished. (Modified 2/28/03)
Remark	MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA). (Modified 2/28/03)
Remark	MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution. (Reactivated 4/1/04)
Remark	MA117	This claim has been assessed a $1.00 user fee.
Remark	MA118	Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.
Remark	MA119	Provider level adjustment for late claim filing applies to this claim. Consider using Reason Code B4
Remark	MA120	Missing/incomplete/invalid CLIA certification number. (Modified 2/28/03)
Remark	MA121	Missing/incomplete/invalid x-ray date. (Modified 12/2/04)
Remark	MA122	Missing/incomplete/invalid initial treatment date. (Modified 12/2/04)
Remark	MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
Remark	MA124	Processed for IME only. Consider using Reason Code 74
Remark	MA125	Per legislation governing this program, payment constitutes payment in full.
Remark	MA126	Pancreas transplant not covered unless kidney transplant performed.
Remark	MA127	Reserved for future use.
Remark	MA128	Missing/incomplete/invalid FDA approval number. (Modified 2/28/03, 3/30/05)
Remark	MA129	This provider was not certified for this procedure on this date of service. Consider using MA120 and Reason Code B7
Remark	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
Remark	MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
Remark	MA132	Adjustment to the pre-demonstration rate.
Remark	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
Remark	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
Remark	N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes. (Modified 2/28/03, 4/1/07, 7/15/13)
Remark	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
Remark	N3	Missing consent form. (Modified 2/28/03) Related to N228

Type	Code	Description
Remark	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB. (Modified 2/28/03, 3/6/2012)
Remark	N5	EOB received from previous payer. Claim not on file.
Remark	N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B. (Modified 2/28/03)
Remark	N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions. (Modified 7/15/13)
Remark	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
Remark	N9	Adjustment represents the estimated amount a previous payer may pay. (Modified 11/18/05)
Remark	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review. (Modified 10/31/02, 7/1/08, 7/15/13, 3/1/2015)
Remark	N11	Denial reversed because of medical review.
Remark	N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare. (Modified 8/1/07)
Remark	N13	Payment based on professional/technical component modifier(s).
Remark	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount. Consider using Reason Code 45
Remark	N15	Services for a newborn must be billed separately.
Remark	N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
Remark	N17	Per admission deductible. Consider using Reason Code 1
Remark	N18	Payment based on the Medicare allowed amount. Consider using N14
Remark	N19	Procedure code incidental to primary procedure.
Remark	N20	Service not payable with other service rendered on the same date.
Remark	N21	Alert: Your line item has been separated into multiple lines to expedite handling. (Modified 8/1/05, 4/1/07)
Remark	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered. (Modified 10/31/02, 2/28/03, 7/1/15)
Remark	N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions. (Modified 8/13/01, 4/1/07)
Remark	N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information. (Modified 2/28/03)
Remark	N25	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
Remark	N26	Missing itemized bill/statement. (Modified 2/28/03, 7/1/2008) Related to N232
Remark	N27	Missing/incomplete/invalid treatment number. (Modified 2/28/03)
Remark	N28	Consent form requirements not fulfilled.
Remark	N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.
Remark	N30	Patient ineligible for this service. (Modified 6/30/03)
Remark	N31	Missing/incomplete/invalid prescribing provider identifier. (Modified 12/2/04)
Remark	N32	Claim must be submitted by the provider who rendered the service. (Modified 6/30/03)
Remark	N33	No record of health check prior to initiation of treatment.
Remark	N34	Incorrect claim form/format for this service. (Modified 11/18/05)
Remark	N35	Program integrity/utilization review decision.

Type	Code	Description
Remark	N36	Claim must meet primary payer’s processing requirements before we can consider payment.
Remark	N37	Missing/incomplete/invalid tooth number/letter. (Modified 2/28/03)
Remark	N38	Missing/incomplete/invalid place of service. Consider using M77
Remark	N39	Procedure code is not compatible with tooth number/letter.
Remark	N40	Missing radiology film(s)/image(s). (Modified 2/1/04, 7/1/08) Related to N242
Remark	N41	Authorization request denied. Consider using Reason Code 39
Remark	N42	Missing mental health assessment.
Remark	N43	Bed hold or leave days exceeded.
Remark	N44	Payer’s share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority. Consider using Reason Code 137
Remark	N45	Payment based on authorized amount.
Remark	N46	Missing/incomplete/invalid admission hour.
Remark	N47	Claim conflicts with another inpatient stay.
Remark	N48	Claim information does not agree with information received from other insurance carrier.
Remark	N49	Court ordered coverage information needs validation.
Remark	N50	Missing/incomplete/invalid discharge information. (Modified 2/28/03)
Remark	N51	Electronic interchange agreement not on file for provider/submitter.
Remark	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
Remark	N53	Missing/incomplete/invalid point of pick-up address. (Modified 2/28/03)
Remark	N54	Claim information is inconsistent with pre-certified/authorized services.
Remark	N55	Procedures for billing with group/referring/performing providers were not followed.
Remark	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. (Modified 2/28/03)
Remark	N57	Missing/incomplete/invalid prescribing date. (Modified 12/2/04) Related to N304
Remark	N58	Missing/incomplete/invalid patient liability amount. (Modified 2/28/03)
Remark	N59	Alert: Please refer to your provider manual for additional program and provider information. (Modified 4/1/07, 11/1/09, 11/1/2015)
Remark	N60	A valid NDC is required for payment of drug claims effective October 02. Consider using M119
Remark	N61	Rebill services on separate claims.
Remark	N62	Dates of service span multiple rate periods. Resubmit separate claims. (Modified 3/8/11)
Remark	N63	Rebill services on separate claim lines.
Remark	N64	The “from” and “to” dates must be different.
Remark	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. (Modified 2/28/03)
Remark	N66	Missing/incomplete/invalid documentation. Consider using N29 or N225.
Remark	N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient’s admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

Type	Code	Description
Remark	N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
Remark	N69	Alert: PPS (Prospective Payment System) code changed by claims processing system. (Modified 6/30/03, 7/1/12, 11/1/2015)
Remark	N70	Consolidated billing and payment applies. (Modified 2/28/02, 11/5/07)
Remark	N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims. (Modified 2/21/02, 6/30/03)
Remark	N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records. (Modified 6/30/03)
Remark	N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents. Consider using MA101 or N200
Remark	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
Remark	N75	Missing/incomplete/invalid tooth surface information. (Modified 2/28/03)
Remark	N76	Missing/incomplete/invalid number of riders. (Modified 2/28/03)
Remark	N77	Missing/incomplete/invalid designated provider number. (Modified 2/28/03)
Remark	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
Remark	N79	Service billed is not compatible with patient location information.
Remark	N80	Missing/incomplete/invalid prenatal screening information. (Modified 2/28/03)
Remark	N81	Procedure billed is not compatible with tooth surface code.
Remark	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
Remark	N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
Remark	N84	Alert: Further installment payments are forthcoming. (Modified 4/1/07, 8/1/07)
Remark	N85	Alert: This is the final installment payment. (Modified 4/1/07, 8/1/07)
Remark	N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
Remark	N87	Home use of biofeedback therapy is not covered.
Remark	N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care. (Modified 4/1/07)
Remark	N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice. (Modified 4/1/07)
Remark	N90	Covered only when performed by the attending physician.
Remark	N91	Services not included in the appeal review.
Remark	N92	This facility is not certified for digital mammography.
Remark	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
Remark	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
Remark	N95	This provider type/provider specialty may not bill this service. (Modified 2/28/03)
Remark	N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.

Type	Code	Description
Remark	N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
Remark	N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
Remark	N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
Remark	N100	PPS (Prospect Payment System) code corrected during adjudication. (Modified 6/30/03, 11/1/2015)
Remark	N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim. Consider using MA105 (Modified 3/14/2014)
Remark	N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.
Remark	N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate. (Modified 6/30/03, 7/1/12, 11/1/13)
Remark	N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov. (Modified 10/31/02, 7/1/10)
Remark	N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 888-355-9165 for RRB EDI information for electronic claims processing. (Modified 7/1/2017)
Remark	N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
Remark	N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
Remark	N108	Missing/incomplete/invalid upgrade information. (Modified 2/28/03)
Remark	N109	Alert: This claim/service was chosen for complex review. (Modified 3/1/2009, 7/1/15)
Remark	N110	This facility is not certified for film mammography.
Remark	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
Remark	N112	This claim is excluded from your electronic remittance advice.
Remark	N113	Only one initial visit is covered per physician, group practice or provider. (Modified 6/30/03)
Remark	N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
Remark	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. (Modified 4/1/04, 7/1/10)
Remark	N116	Alert: This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care. (Modified 11/1/2016)

Type	Code	Description
Remark	N117	This service is paid only once in a patient's lifetime. (Modified 6/30/03)
Remark	N118	This service is not paid if billed more than once every 28 days.
Remark	N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days. (Modified 6/30/03)
Remark	N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode. (Modified 6/30/03)
Remark	N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay. (Modified 8/1/04, 6/30/03)
Remark	N122	Add-on code cannot be billed by itself. (Modified 8/1/05)
Remark	N123	Alert: This is a split service and represents a portion of the units from the originally submitted service. (Modified 3/1/2016)
Remark	N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
Remark	N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office. (Modified 8/1/05. Also refer to N356)
Remark	N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
Remark	N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them. (Modified 8/1/04
Remark	N128	This amount represents the prior to coverage portion of the allowance.
Remark	N129	Not eligible due to the patient's age. (Modified 8/1/07)
Remark	N130	Consult plan benefit documents/guidelines for information about restrictions for this service. (Modified 4/1/07, 7/1/08, 11/1/09)
Remark	N131	Total payments under multiple contracts cannot exceed the allowance for this service.
Remark	N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified. (Modified 4/1/07)
Remark	N133	Alert: Services for predetermination and services requesting payment are being processed separately. (Modified 4/1/07)
Remark	N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service. (Modified 4/1/07)
Remark	N135	Record fees are the patient's responsibility and limited to the specified co-payment.
Remark	N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548. (Modified 4/1/07)
Remark	N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority. (Modified 8/1/04, 2/28/03, 4/1/07)
Remark	N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review. (Modified 4/1/07)

Type	Code	Description
Remark	N139	Alert: Under 32 CFR 199.13, a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. (Modified 4/1/07, 3/1/2017)
Remark	N140	Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. (Modified 4/1/07)
Remark	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
Remark	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
Remark	N143	The patient was not in a hospice program during all or part of the service dates billed.
Remark	N144	The rate changed during the dates of service billed.
Remark	N145	Missing/incomplete/invalid provider identifier for this place of service.
Remark	N146	Missing screening document. (Modified 8/1/04) Related to N243
Remark	N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
Remark	N148	Missing/incomplete/invalid date of last menstrual period.
Remark	N149	Rebill all applicable services on a single claim.
Remark	N150	Missing/incomplete/invalid model number.
Remark	N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
Remark	N152	Missing/incomplete/invalid replacement claim information.
Remark	N153	Missing/incomplete/invalid room and board rate.
Remark	N154	Alert: This payment was delayed for correction of provider's mailing address. (Modified 4/1/07)
Remark	N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records. (Modified 4/1/07)
Remark	N156	Alert: The patient is responsible for the difference between the approved treatment and the elective treatment. (Modified 4/1/07)
Remark	N157	Transportation to/from this destination is not covered. (Modified 2/1/04)
Remark	N158	Transportation in a vehicle other than an ambulance is not covered.
Remark	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
Remark	N160	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service. (Modified 2/1/04)
Remark	N161	This drug/service/supply is covered only when the associated service is covered.
Remark	N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future. (Modified 4/1/07)
Remark	N163	Medical record does not support code billed per the code definition.
Remark	N164	Transportation to/from this destination is not covered. Consider using N157
Remark	N165	Transportation in a vehicle other than an ambulance is not covered. Consider using N158)
Remark	N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. Consider using N159
Remark	N167	Charges exceed the post-transplant coverage limit.

Type	Code	Description
Remark	N168	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service. Consider using N160
Remark	N169	This drug/service/supply is covered only when the associated service is covered. Consider using N161
Remark	N170	A new/revised/renewed certificate of medical necessity is needed.
Remark	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.
Remark	N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
Remark	N173	No qualifying hospital stay dates were provided for this episode of care.
Remark	N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
Remark	N175	Missing review organization approval. (Modified 8/1/04, 2/29/08) Related to N241
Remark	N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
Remark	N177	Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made. (Modified 6/30/03, 4/1/07)
Remark	N178	Missing pre-operative images/visual field results. (Modified 8/1/04, 11/1/13) Related to N244
Remark	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
Remark	N180	This item or service does not meet the criteria for the category under which it was billed.
Remark	N181	Additional information is required from another provider involved in this service. (Modified 12/1/06)
Remark	N182	This claim/service must be billed according to the schedule for this plan.
Remark	N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits. (Modified 4/1/07)
Remark	N184	Rebill technical and professional components separately.
Remark	N185	Alert: Do not resubmit this claim/service. (Modified 4/1/07)
Remark	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
Remark	N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. (Modified 4/1/07)
Remark	N188	The approved level of care does not match the procedure code submitted.
Remark	N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions. (Modified 4/1/07)
Remark	N190	Missing contract indicator. (Modified 8/1/04) Related to N229
Remark	N191	The provider must update insurance information directly with payer.
Remark	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
Remark	N193	Alert: Specific federal/state/local program may cover this service through another payer. (Modified 11/1/2015)
Remark	N194	Technical component not paid if provider does not own the equipment used.
Remark	N195	The technical component must be billed separately.
Remark	N196	Alert: Patient eligible to apply for other coverage which may be primary. (Modified 4/1/07)
Remark	N197	The subscriber must update insurance information directly with payer.
Remark	N198	Rendering provider must be affiliated with the pay-to provider.
Remark	N199	Additional payment/recoupment approved based on payer-initiated review/audit. (Modified 8/1/06)
Remark	N200	The professional component must be billed separately.

Type	Code	Description
Remark	N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents. Consider using N538
Remark	N202	Alert: Additional information/explanation will be sent separately. (Modified 4/1/07, 11/1/09, 3/14/2014, 11/1/2015)
Remark	N203	Missing/incomplete/invalid anesthesia time/units. (Modified 3/14/2014)
Remark	N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months
Remark	N205	Information provided was illegible. (Modified 3/14/2014)
Remark	N206	The supporting documentation does not match the information sent on the claim. (Modified 3/6/12)
Remark	N207	Missing/incomplete/invalid weight. (Modified 11/18/05)
Remark	N208	Missing/incomplete/invalid DRG code. (Modified 3/14/2014)
Remark	N209	Missing/incomplete/invalid taxpayer identification number (TIN). (Modified 7/1/08)
Remark	N210	Alert: You may appeal this decision. (Modified 4/1/07, 3/14/2014)
Remark	N211	Alert: You may not appeal this decision. (Modified 4/1/07, 3/14/2014)
Remark	N212	Charges processed under a Point of Service benefit . (Modified 3/14/2014)
Remark	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. (Modified 3/14/2014)
Remark	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s). (Modified 3/14/2014)
Remark	N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination. (Modified 4/1/07)
Remark	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. (Modified 3/1/2010, 3/14/2014)
Remark	N217	We pay only one site of service per provider per claim. (Modified 3/14/2014)
Remark	N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
Remark	N219	Payment based on previous payer's allowed amount.
Remark	N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute. (Modified 4/1/07)
Remark	N221	Missing Admitting History and Physical report.
Remark	N222	Incomplete/invalid Admitting History and Physical report.
Remark	N223	Missing documentation of benefit to the patient during initial treatment period.
Remark	N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.
Remark	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.
Remark	N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.
Remark	N227	Incomplete/invalid Certificate of Medical Necessity.
Remark	N228	Incomplete/invalid consent form.
Remark	N229	Incomplete/invalid contract indicator.
Remark	N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
Remark	N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
Remark	N232	Incomplete/invalid itemized bill/statement. (Modified 7/1/08)
Remark	N233	Incomplete/invalid operative note/report. (Modified 7/1/08)
Remark	N234	Incomplete/invalid oxygen certification/re-certification.

Type	Code	Description
Remark	N235	Incomplete/invalid pacemaker registration form.
Remark	N236	Incomplete/invalid pathology report.
Remark	N237	Incomplete/invalid patient medical record for this service.
Remark	N238	Incomplete/invalid physician certified plan of care. (Modified 3/14/2014)
Remark	N239	Incomplete/invalid physician financial relationship form.
Remark	N240	Incomplete/invalid radiology report.
Remark	N241	Incomplete/invalid review organization approval. (Modified 2/29/08)
Remark	N242	Incomplete/invalid radiology film(s)/image(s). (Modified 7/1/08)
Remark	N243	Incomplete/invalid/not approved screening document.
Remark	N244	Incomplete/Invalid pre-operative images/visual field results. (Modified 11/1/2013)
Remark	N245	Incomplete/invalid plan information for other insurance . (Modified 3/14/2014)
Remark	N246	State regulated patient payment limitations apply to this service.
Remark	N247	Missing/incomplete/invalid assistant surgeon taxonomy.
Remark	N248	Missing/incomplete/invalid assistant surgeon name.
Remark	N249	Missing/incomplete/invalid assistant surgeon primary identifier.
Remark	N250	Missing/incomplete/invalid assistant surgeon secondary identifier.
Remark	N251	Missing/incomplete/invalid attending provider taxonomy.
Remark	N252	Missing/incomplete/invalid attending provider name.
Remark	N253	Missing/incomplete/invalid attending provider primary identifier.
Remark	N254	Missing/incomplete/invalid attending provider secondary identifier.
Remark	N255	Missing/incomplete/invalid billing provider taxonomy.
Remark	N256	Missing/incomplete/invalid billing provider/supplier name.
Remark	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
Remark	N258	Missing/incomplete/invalid billing provider/supplier address.
Remark	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
Remark	N260	Missing/incomplete/invalid billing provider/supplier contact information.
Remark	N261	Missing/incomplete/invalid operating provider name.
Remark	N262	Missing/incomplete/invalid operating provider primary identifier.
Remark	N263	Missing/incomplete/invalid operating provider secondary identifier.
Remark	N264	Missing/incomplete/invalid ordering provider name.
Remark	N265	Missing/incomplete/invalid ordering provider primary identifier.
Remark	N266	Missing/incomplete/invalid ordering provider address.
Remark	N267	Missing/incomplete/invalid ordering provider secondary identifier.
Remark	N268	Missing/incomplete/invalid ordering provider contact information.
Remark	N269	Missing/incomplete/invalid other provider name.
Remark	N270	Missing/incomplete/invalid other provider primary identifier.
Remark	N271	Missing/incomplete/invalid other provider secondary identifier.

Type	Code	Description
Remark	N272	Missing/incomplete/invalid other payer attending provider identifier.
Remark	N273	Missing/incomplete/invalid other payer operating provider identifier.
Remark	N274	Missing/incomplete/invalid other payer other provider identifier.
Remark	N275	Missing/incomplete/invalid other payer purchased service provider identifier.
Remark	N276	Missing/incomplete/invalid other payer referring provider identifier.
Remark	N277	Missing/incomplete/invalid other payer rendering provider identifier.
Remark	N278	Missing/incomplete/invalid other payer service facility provider identifier.
Remark	N279	Missing/incomplete/invalid pay-to provider name.
Remark	N280	Missing/incomplete/invalid pay-to provider primary identifier.
Remark	N281	Missing/incomplete/invalid pay-to provider address.
Remark	N282	Missing/incomplete/invalid pay-to provider secondary identifier.
Remark	N283	Missing/incomplete/invalid purchased service provider identifier.
Remark	N284	Missing/incomplete/invalid referring provider taxonomy.
Remark	N285	Missing/incomplete/invalid referring provider name.
Remark	N286	Missing/incomplete/invalid referring provider primary identifier.
Remark	N287	Missing/incomplete/invalid referring provider secondary identifier.
Remark	N288	Missing/incomplete/invalid rendering provider taxonomy.
Remark	N289	Missing/incomplete/invalid rendering provider name.
Remark	N290	Missing/incomplete/invalid rendering provider primary identifier.
Remark	N291	Missing/incomplete/invalid rendering provider secondary identifier.
Remark	N292	Missing/incomplete/invalid service facility name.
Remark	N293	Missing/incomplete/invalid service facility primary identifier.
Remark	N294	Missing/incomplete/invalid service facility primary address.
Remark	N295	Missing/incomplete/invalid service facility secondary identifier.
Remark	N296	Missing/incomplete/invalid supervising provider name.
Remark	N297	Missing/incomplete/invalid supervising provider primary identifier.
Remark	N298	Missing/incomplete/invalid supervising provider secondary identifier.
Remark	N299	Missing/incomplete/invalid occurrence date(s).
Remark	N300	Missing/incomplete/invalid occurrence span date(s).
Remark	N301	Missing/incomplete/invalid procedure date(s).
Remark	N302	Missing/incomplete/invalid other procedure date(s).
Remark	N303	Missing/incomplete/invalid principal procedure date.
Remark	N304	Missing/incomplete/invalid dispensed date.
Remark	N305	Missing/incomplete/invalid injury/accident date. (Modified 11/1/2016)
Remark	N306	Missing/incomplete/invalid acute manifestation date.
Remark	N307	Missing/incomplete/invalid adjudication or payment date.
Remark	N308	Missing/incomplete/invalid appliance placement date.

Type	Code	Description
Remark	N309	Missing/incomplete/invalid assessment date.
Remark	N310	Missing/incomplete/invalid assumed or relinquished care date.
Remark	N311	Missing/incomplete/invalid authorized to return to work date.
Remark	N312	Missing/incomplete/invalid begin therapy date.
Remark	N313	Missing/incomplete/invalid certification revision date.
Remark	N314	Missing/incomplete/invalid diagnosis date.
Remark	N315	Missing/incomplete/invalid disability from date.
Remark	N316	Missing/incomplete/invalid disability to date.
Remark	N317	Missing/incomplete/invalid discharge hour.
Remark	N318	Missing/incomplete/invalid discharge or end of care date.
Remark	N319	Missing/incomplete/invalid hearing or vision prescription date.
Remark	N320	Missing/incomplete/invalid Home Health Certification Period.
Remark	N321	Missing/incomplete/invalid last admission period.
Remark	N322	Missing/incomplete/invalid last certification date.
Remark	N323	Missing/incomplete/invalid last contact date.
Remark	N324	Missing/incomplete/invalid last seen/visit date.
Remark	N325	Missing/incomplete/invalid last worked date.
Remark	N326	Missing/incomplete/invalid last x-ray date.
Remark	N327	Missing/incomplete/invalid other insured birth date.
Remark	N328	Missing/incomplete/invalid Oxygen Saturation Test date.
Remark	N329	Missing/incomplete/invalid patient birth date.
Remark	N330	Missing/incomplete/invalid patient death date.
Remark	N331	Missing/incomplete/invalid physician order date.
Remark	N332	Missing/incomplete/invalid prior hospital discharge date.
Remark	N333	Missing/incomplete/invalid prior placement date.
Remark	N334	Missing/incomplete/invalid re-evaluation date. (Modified 3/14/2014)
Remark	N335	Missing/incomplete/invalid referral date.
Remark	N336	Missing/incomplete/invalid replacement date.
Remark	N337	Missing/incomplete/invalid secondary diagnosis date.
Remark	N338	Missing/incomplete/invalid shipped date.
Remark	N339	Missing/incomplete/invalid similar illness or symptom date.
Remark	N340	Missing/incomplete/invalid subscriber birth date.
Remark	N341	Missing/incomplete/invalid surgery date.
Remark	N342	Missing/incomplete/invalid test performed date.
Remark	N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
Remark	N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
Remark	N345	Date range not valid with units submitted.

Type	Code	Description
Remark	N346	Missing/incomplete/invalid oral cavity designation code.
Remark	N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
Remark	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.
Remark	N349	The administration method and drug must be reported to adjudicate this service.
Remark	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. (Modified 7/1/08)
Remark	N351	Service date outside of the approved treatment plan service dates.
Remark	N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit. (Modified 4/1/07)
Remark	N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim. (Modified 4/1/07)
Remark	N354	Incomplete/invalid invoice. (Modified 3/14/2014)
Remark	N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law
Remark	N356	Not covered when performed with, or subsequent to, a non-covered service. (Modified 3/8/11)
Remark	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
Remark	N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. (Modified 4/1/07)
Remark	N359	Missing/incomplete/invalid height.
Remark	N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim. (Modified 4/1/07)
Remark	N361	Payment adjusted based on multiple diagnostic imaging procedure rules (Modified 12/1/06) Consider using Reason Code 59
Remark	N362	The number of Days or Units of Service exceeds our acceptable maximum.
Remark	N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination. (Modified 4/1/07)
Remark	N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts. (Modified 4/1/07)
Remark	N365	This procedure code is not payable. It is for reporting/information purposes only. Consider Using CARC 246 or N620
Remark	N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
Remark	N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account. (Modified 4/1/07, 11/5/07, 7/1/08)
Remark	N368	You must appeal the determination of the previously adjudicated claim.
Remark	N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
Remark	N370	Billing exceeds the rental months covered/approved by the payer.
Remark	N371	Alert: title of this equipment must be transferred to the patient.

Type	Code	Description
Remark	N372	Only reasonable and necessary maintenance/service charges are covered.
Remark	N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.
Remark	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
Remark	N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
Remark	N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
Remark	N377	Payment based on a processed replacement claim. (Modified 11/5/07)
Remark	N378	Missing/incomplete/invalid prescription quantity.
Remark	N379	Claim level information does not match line level information.
Remark	N380	The original claim has been processed, submit a corrected claim.
Remark	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. (Modified 7/1/15)
Remark	N382	Missing/incomplete/invalid patient identifier.
Remark	N383	Not covered when deemed cosmetic. (Modified 3/8/11)
Remark	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
Remark	N385	Notification of admission was not timely according to published plan procedures. (Modified 11/5/07)
Remark	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD. (Modified 7/1/2010)
Remark	N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (Modified 3/1/2009)
Remark	N388	Missing/incomplete/invalid prescription number. (Modified 3/14/2014)
Remark	N389	Duplicate prescription number submitted.
Remark	N390	This service/report cannot be billed separately. (Modified 7/1/08)
Remark	N391	Missing emergency department records.
Remark	N392	Incomplete/invalid emergency department records.
Remark	N393	Missing progress notes/report. (Modified 7/1/08)
Remark	N394	Incomplete/invalid progress notes/report. (Modified 7/1/08)
Remark	N395	Missing laboratory report.
Remark	N396	Incomplete/invalid laboratory report.
Remark	N397	Benefits are not available for incomplete service(s)/undelivered item(s).
Remark	N398	Missing elective consent form.
Remark	N399	Incomplete/invalid elective consent form.
Remark	N400	Alert: Electronically enabled providers should submit claims electronically.
Remark	N401	Missing periodontal charting.
Remark	N402	Incomplete/invalid periodontal charting.
Remark	N403	Missing facility certification.
Remark	N404	Incomplete/invalid facility certification.
Remark	N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.

Type	Code	Description
Remark	N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
Remark	N407	You are not an approved submitter for this transmission format.
Remark	N408	This payer does not cover deductibles assessed by a previous payer.
Remark	N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
Remark	N410	Not covered unless the prescription changes. (Modified 3/8/11)
Remark	N411	This service is allowed one time in a 6-month period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N412	This service is allowed 2 times in a 12-month period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N413	This service is allowed 2 times in a benefit year. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N414	This service is allowed 4 times in a 12-month period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N415	This service is allowed 1 time in an 18-month period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N416	This service is allowed 1 time in a 3-year period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N417	This service is allowed 1 time in a 5-year period. (Modified 2/1/2009, Reactivated 7/1/2016)
Remark	N418	Misrouted claim. See the payer's claim submission instructions.
Remark	N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
Remark	N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
Remark	N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision. (Modified 2/29/08, typo fixed 5/8/08)
Remark	N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. (Typo fixed 5/8/08)
Remark	N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
Remark	N424	Patient does not reside in the geographic area required for this type of payment.
Remark	N425	Statutorily excluded service(s).
Remark	N426	No coverage when self-administered.
Remark	N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.
Remark	N428	Not covered when performed in this place of service. (Modified 3/8/11)
Remark	N429	Not covered when considered routine. (Modified 3/8/11)
Remark	N430	Procedure code is inconsistent with the units billed.
Remark	N431	Not covered with this procedure. (Modified 3/8/11)
Remark	N432	Alert: Adjustment based on a Recovery Audit. (Modified 7/1/15)
Remark	N433	Resubmit this claim using only your National Provider Identifier (NPI). (Modified 3/14/2014)
Remark	N434	Missing/Incomplete/Invalid Present on Admission indicator.
Remark	N435	Exceeds number/frequency approved /allowed within time period without support documentation.
Remark	N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made.
Remark	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.
Remark	N438	This jurisdiction only accepts paper claims. (Modified 3/14/2014)
Remark	N439	Missing anesthesia physical status report/indicators.
Remark	N440	Incomplete/invalid anesthesia physical status report/indicators.
Remark	N441	This missed/cancelled appointment is not covered. (Modified 7/15/2013)

Type	Code	Description
Remark	N442	Payment based on an alternate fee schedule.
Remark	N443	Missing/incomplete/invalid total time or begin/end time.
Remark	N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.
Remark	N445	Missing document for actual cost or paid amount.
Remark	N446	Incomplete/invalid document for actual cost or paid amount.
Remark	N447	Payment is based on a generic equivalent as required documentation was not provided.
Remark	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. (Modified 3/14/2014)
Remark	N449	Payment based on a comparable drug/service/supply.
Remark	N450	Covered only when performed by the primary treating physician or the designee.
Remark	N451	Missing Admission Summary Report.
Remark	N452	Incomplete/invalid Admission Summary Report.
Remark	N453	Missing Consultation Report.
Remark	N454	Incomplete/invalid Consultation Report.
Remark	N455	Missing Physician Order.
Remark	N456	Incomplete/invalid Physician Order.
Remark	N457	Missing Diagnostic Report.
Remark	N458	Incomplete/invalid Diagnostic Report.
Remark	N459	Missing Discharge Summary.
Remark	N460	Incomplete/invalid Discharge Summary.
Remark	N461	Missing Nursing Notes.
Remark	N462	Incomplete/invalid Nursing Notes.
Remark	N463	Missing support data for claim.
Remark	N464	Incomplete/invalid support data for claim.
Remark	N465	Missing Physical Therapy Notes/Report.
Remark	N466	Incomplete/invalid Physical Therapy Notes/Report.
Remark	N467	Missing Tests and Analysis Report. (Modified 3/14/2014)
Remark	N468	Incomplete/invalid Report of Tests and Analysis Report.
Remark	N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
Remark	N470	This payment will complete the mandatory medical reimbursement limit.
Remark	N471	Missing/incomplete/invalid HIPPS Rate Code.
Remark	N472	Payment for this service has been issued to another provider.
Remark	N473	Missing certification.
Remark	N474	Incomplete/invalid certification. (Modified 3/14/2014)
Remark	N475	Missing completed referral form.
Remark	N476	Incomplete/invalid completed referral form. (Modified 3/14/2014)
Remark	N477	Missing Dental Models.

Type	Code	Description
Remark	N478	Incomplete/invalid Dental Models. (Modified 3/14/2014)
Remark	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Remark	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Remark	N481	Missing Models.
Remark	N482	Incomplete/invalid Models. (Modified 3/14/2014)
Remark	N483	Missing Periodontal Charts. (Modified 11/1/2014)
Remark	N484	Incomplete/invalid Periodontal Charts. (Modified 3/14/2014, 11/1/2014)
Remark	N485	Missing Physical Therapy Certification.
Remark	N486	Incomplete/invalid Physical Therapy Certification.
Remark	N487	Missing Prosthetics or Orthotics Certification.
Remark	N488	Incomplete/invalid Prosthetics or Orthotics Certification. (Modified 3/14/2014)
Remark	N489	Missing referral form.
Remark	N490	Incomplete/invalid referral form. (Modified 3/14/2014)
Remark	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.
Remark	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
Remark	N493	Missing Doctor First Report of Injury.
Remark	N494	Incomplete/invalid Doctor First Report of Injury.
Remark	N495	Missing Supplemental Medical Report.
Remark	N496	Incomplete/invalid Supplemental Medical Report.
Remark	N497	Missing Medical Permanent Impairment or Disability Report.
Remark	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.
Remark	N499	Missing Medical Legal Report.
Remark	N500	Incomplete/invalid Medical Legal Report.
Remark	N501	Missing Vocational Report.
Remark	N502	Incomplete/invalid Vocational Report.
Remark	N503	Missing Work Status Report.
Remark	N504	Incomplete/invalid Work Status Report.
Remark	N505	Alert: This response includes only services that could be estimated in real-time. No estimate will be provided for the services that could not be estimated in real-time. (Modified 3/1/2017)
Remark	N506	Alert: This is an estimate of the member’s liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.
Remark	N507	Plan distance requirements have not been met.
Remark	N508	Alert: This real-time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions. (Modified 3/1/2017)
Remark	N509	Alert: A current inquiry shows the member’s Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.

Type	Code	Description
Remark	N510	Alert: A current inquiry shows the member’s Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
Remark	N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.
Remark	N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.
Remark	N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.
Remark	N514	Consult plan benefit documents/guidelines for information about restrictions for this service. Consider using N130
Remark	N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead)
Remark	N516	Records indicate a mismatch between the submitted NPI and EIN.
Remark	N517	Resubmit a new claim with the requested information.
Remark	N518	No separate payment for accessories when furnished for use with oxygen equipment.
Remark	N519	Invalid combination of HCPCS modifiers.
Remark	N520	Alert: Payment made from a Consumer Spending Account.
Remark	N521	Mismatch between the submitted provider information and the provider information stored in our system.
Remark	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
Remark	N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.
Remark	N524	Based on policy this payment constitutes payment in full.
Remark	N525	These services are not covered when performed within the global period of another service.
Remark	N526	Not qualified for recovery based on employer size.
Remark	N527	We processed this claim as the primary payer prior to receiving the recovery demand.
Remark	N528	Patient is entitled to benefits for Institutional Services only. (Modified 7/1/10)
Remark	N529	Patient is entitled to benefits for Professional Services only. (Modified 7/1/10)
Remark	N530	Not Qualified for Recovery based on enrollment information. (Modified 7/1/10)
Remark	N531	Not qualified for recovery based on direct payment of premium.
Remark	N532	Not qualified for recovery based on disability and working status.
Remark	N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.
Remark	N534	This is an individual policy, the employer does not participate in plan sponsorship.
Remark	N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.
Remark	N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.
Remark	N537	We have examined claims history and no records of the services have been found.
Remark	N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
Remark	N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.
Remark	N540	Payment adjusted based on the interrupted stay policy.
Remark	N541	Mismatch between the submitted insurance type code and the information stored in our system.

Type	Code	Description
Remark	N542	Missing income verification.
Remark	N543	Incomplete/invalid income verification. (Modified 3/14/2014)
Remark	N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future. (Modified 3/14/2014)
Remark	N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.
Remark	N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.
Remark	N547	A refund request (Frequency Type Code 8) was processed previously.
Remark	N548	Alert: Patient's calendar year deductible has been met.
Remark	N549	Alert: Patient's calendar year out-of-pocket maximum has been met.
Remark	N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.
Remark	N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
Remark	N552	Payment adjusted to reverse a previous withhold/bonus amount.
Remark	N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.
Remark	N554	Missing/Incomplete/Invalid Family Planning Indicator. (Modified 3/14/2014)
Remark	N555	Missing medication list.
Remark	N556	Incomplete/invalid medication list.
Remark	N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.
Remark	N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.
Remark	N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.
Remark	N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.
Remark	N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.
Remark	N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.
Remark	N563	Alert: Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service. Related to M39 (Modified 11/1/2015)
Remark	N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.
Remark	N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. (Modified 3/1/13)
Remark	N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.
Remark	N567	Not covered when considered preventative.
Remark	N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
Remark	N569	Not covered when performed for the reported diagnosis.
Remark	N570	Missing/incomplete/invalid credentialing data. (Modified 3/14/2014)
Remark	N571	Alert: Payment will be issued quarterly by another payer/contractor.
Remark	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.

Type	Code	Description
Remark	N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor.
Remark	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
Remark	N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.
Remark	N576	Services not related to the specific incident/claim/accident/loss being reported.
Remark	N577	Personal Injury Protection (PIP) Coverage.
Remark	N578	Coverages do not apply to this loss.
Remark	N579	Medical Payments Coverage (MPC).
Remark	N580	Determination based on the provisions of the insurance policy.
Remark	N581	Investigation of coverage eligibility is pending.
Remark	N582	Benefits suspended pending the patient's cooperation.
Remark	N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.
Remark	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.
Remark	N585	Benefits are no longer available based on a final injury settlement.
Remark	N586	The injured party does not qualify for benefits.
Remark	N587	Policy benefits have been exhausted.
Remark	N588	The patient has instructed that medical claims/bills are not to be paid.
Remark	N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.
Remark	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.
Remark	N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).
Remark	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.
Remark	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).
Remark	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.
Remark	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.
Remark	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.
Remark	N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.
Remark	N598	Health care policy coverage is primary.
Remark	N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
Remark	N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.
Remark	N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.
Remark	N602	Adjusted based on the Redbook maximum allowance.

Type	Code	Description
Remark	N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.
Remark	N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.
Remark	N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.
Remark	N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.
Remark	N607	Service provided for non-compensable condition(s).
Remark	N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.
Remark	N609	80% of the provider's billed amount is being recommended for payment according to Act 6. (Modified 3/14/2014)
Remark	N610	Alert: Payment based on an appropriate level of care.
Remark	N611	Claim in litigation. Contact insurer for more information.
Remark	N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
Remark	N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.
Remark	N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).
Remark	N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under 45 CFR 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. (Modified 3/1/2017)
Remark	N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.
Remark	N617	This enrollee is in the second or third month of the advance premium tax credit grace period.
Remark	N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.
Remark	N619	Coverage terminated for non-payment of premium.
Remark	N620	Alert: This procedure code is for quality reporting/informational purposes only.
Remark	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.
Remark	N622	Not covered based on the date of injury/accident.
Remark	N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
Remark	N624	The associated Workers' Compensation claim has been withdrawn.
Remark	N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.
Remark	N626	New or established patient E/M codes are not payable with chiropractic care codes.
Remark	N627	Service not payable per managed care contract. Consider Use CARC 256
Remark	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
Remark	N629	Reviews/documentation/notes/summaries/reports/charts not requested.
Remark	N630	Referral not authorized by attending physician.
Remark	N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.

Type	Code	Description
Remark	N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due. Consider using W8
Remark	N633	Additional anesthesia time units are not allowed.
Remark	N634	The allowance is calculated based on anesthesia time units.
Remark	N635	The Allowance is calculated based on the anesthesia base units plus time.
Remark	N636	Adjusted because this is reimbursable only once per injury.
Remark	N637	Consultations are not allowed once treatment has been rendered by the same provider.
Remark	N638	Reimbursement has been made according to the home health fee schedule.
Remark	N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
Remark	N640	Exceeds number/frequency approved/allowed within time period.
Remark	N641	Reimbursement has been based on the number of body areas rated.
Remark	N642	Adjusted when billed as individual tests instead of as a panel.
Remark	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.
Remark	N644	Reimbursement has been made according to the bilateral procedure rule.
Remark	N645	Mark-up allowance. (Modified 3/14/2014)
Remark	N646	Reimbursement has been adjusted based on the guidelines for an assistant.
Remark	N647	Adjusted based on diagnosis-related group (DRG).
Remark	N648	Adjusted based on Stop Loss.
Remark	N649	Payment based on invoice.
Remark	N650	This policy was not in effect for this date of loss. No coverage is available.
Remark	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.
Remark	N652	The date of service is before the date of loss.
Remark	N653	The date of injury does not match the reported date of loss.
Remark	N654	Adjusted based on achievement of maximum medical improvement (MMI).
Remark	N655	Payment based on provider's geographic region.
Remark	N656	An interest payment is being made because benefits are being paid outside the statutory requirement.
Remark	N657	This should be billed with the appropriate code for these services.
Remark	N658	The billed service(s) are not considered medical expenses.
Remark	N659	This item is exempt from sales tax.
Remark	N660	Sales tax has been included in the reimbursement.
Remark	N661	Documentation does not support that the services rendered were medically necessary.
Remark	N662	Alert: Consideration of payment will be made upon receipt of a final bill.
Remark	N663	Adjusted based on an agreed amount.
Remark	N664	Adjusted based on a legal settlement.
Remark	N665	Services by an unlicensed provider are not reimbursable.
Remark	N666	Only one evaluation and management code at this service level is covered during the course of care.
Remark	N667	Missing prescription. (Modified 3/14/2014)
Remark	N668	Incomplete/invalid prescription. (Modified 3/14/2014)

Type	Code	Description
Remark	N669	Adjusted based on the Medicare fee schedule.
Remark	N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
Remark	N671	Payment based on a jurisdiction cost-charge ratio.
Remark	N672	Alert: Amount applied to Health Insurance Offset.
Remark	N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.
Remark	N674	Not covered unless a pre-requisite procedure/service has been provided.
Remark	N675	Additional information is required from the injured party.
Remark	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
Remark	N677	Alert: Films/Images will not be returned.
Remark	N678	Missing post-operative images/visual field results.
Remark	N679	Incomplete/Invalid post-operative images/visual field results.
Remark	N680	Missing/Incomplete/Invalid date of previous dental extractions.
Remark	N681	Missing/Incomplete/Invalid full arch series.
Remark	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.
Remark	N683	Missing/Incomplete/Invalid prior treatment documentation.
Remark	N684	Payment denied as this is a specialty claim submitted as a general claim.
Remark	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
Remark	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.
Remark	N687	Alert: This reversal is due to a retroactive disenrollment. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N688	Alert: This reversal is due to a medical or utilization review decision. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N689	Alert: This reversal is due to a retroactive rate change. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N690	Alert: This reversal is due to a provider submitted appeal. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N691	Alert: This reversal is due to a patient submitted appeal. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N692	Alert: This reversal is due to an incorrect rate on the initial adjudication. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N693	Alert: This reversal is due to a cancellation of the claim by the provider. (Modified 3/14/2014)
Remark	N694	Alert: This reversal is due to a resubmission/change to the claim by the provider.
Remark	N695	Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudication.
Remark	N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment. To be used with claim/service reversal. (Modified 3/14/2014)
Remark	N698	Alert: This reversal is due to non-payment of the health insurance premiums (Health Insurance Exchange or other) by the end of the premium payment grace period, resulting in loss of coverage. To be used with claim/service reversal. (Modified 3/14/2014, 11/1/2015)
Remark	N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.
Remark	N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.

Type	Code	Description
Remark	N701	Payment adjusted based on the Value-based Payment Modifier.
Remark	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
Remark	N703	This service is incompatible with previously adjudicated claims or claims in process.
Remark	N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted. (Modified 3/14/2014)
Remark	N705	Incomplete/invalid documentation.
Remark	N706	Missing documentation.
Remark	N707	Incomplete/invalid orders.
Remark	N708	Missing orders.
Remark	N709	Incomplete/invalid notes.
Remark	N710	Missing notes.
Remark	N711	Incomplete/invalid summary.
Remark	N712	Missing summary.
Remark	N713	Incomplete/invalid report.
Remark	N714	Missing report.
Remark	N715	Incomplete/invalid chart.
Remark	N716	Missing chart.
Remark	N717	Incomplete/Invalid documentation of face-to-face examination.
Remark	N718	Missing documentation of face-to-face examination.
Remark	N719	Penalty applied based on plan requirements not being met.
Remark	N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient’s payment and the amount shown as patient responsibility on this notice.
Remark	N721	This service is only covered when performed as part of a clinical trial.
Remark	N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.
Remark	N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.
Remark	N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.
Remark	N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
Remark	N726	A conditional payment is not allowed.
Remark	N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
Remark	N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
Remark	N729	Missing patient medical/dental record for this service.
Remark	N730	Incomplete/invalid patient medical/dental record for this service.
Remark	N731	Incomplete/Invalid mental health assessment.
Remark	N732	Services performed at an unlicensed facility are not reimbursable.
Remark	N733	Regulatory surcharges are paid directly to the state.
Remark	N734	The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.
Remark	N735	Adjustment without review of medical/dental record because the requested records were not received or were not received timely.

Type	Code	Description
Remark	N736	Incomplete/invalid Sleep Study Report.
Remark	N737	Missing Sleep Study Report.
Remark	N738	Incomplete/invalid Vein Study Report.
Remark	N739	Missing Vein Study Report.
Remark	N740	The member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.
Remark	N741	This is a site neutral payment.
Remark	N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html (Modified 11/1/2015)
Remark	N743	Adjusted because the services may be related to an employment accident.
Remark	N744	Adjusted because the services may be related to an auto/other accident. (Modified 3/1/2017)
Remark	N745	Missing Ambulance Report.
Remark	N746	Incomplete/invalid Ambulance Report.
Remark	N747	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.
Remark	N748	Adjusted because the related hospital charges have not been received.
Remark	N749	Missing Blood Gas Report.
Remark	N750	Incomplete/invalid Blood Gas Report.
Remark	N751	Adjusted because the patient is covered under a Medicare Part D plan. (Modified 7/1/2017)
Remark	N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).
Remark	N753	Missing/incomplete/invalid Attachment Control Number.
Remark	N754	Missing/incomplete/invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.
Remark	N755	Missing/incomplete/invalid ICD Indicator. (Modified 3/1/2016)
Remark	N756	Missing/incomplete/invalid point of drop-off address.
Remark	N757	Adjusted based on the Federal Indian Fees schedule (MLR).
Remark	N758	Adjusted based on the prior authorization decision.
Remark	N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.
Remark	N760	This facility is not authorized to receive payment for the service(s).
Remark	N761	This provider is not authorized to receive payment for the service(s).
Remark	N762	This facility is not certified for Tomosynthesis (3-D) mammography.
Remark	N763	The demonstration code is not appropriate for this claim; resubmit without a demonstration code.
Remark	N764	Missing/incomplete/invalid Hematocrit (HCT) value.
Remark	N765	This payer does not cover coinsurance assessed by a previous payer. (Modified 3/1/2018)
Remark	N766	This payer does not cover co-payment assessed by a previous payer.
Remark	N767	The Medicaid state requires provider to be enrolled in the member’s Medicaid state program prior to any claim benefits being processed.
Remark	N768	Incomplete/invalid initial evaluation report.
Remark	N769	A lateral diagnosis is required.
Remark	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.

Type	Code	Description
Remark	N771	Alert: Under Federal law you cannot charge more than the limiting charge amount.
Remark	N772	Alert: Rebill urgent/emergent and ancillary services separately.
Remark	N773	Drug supplied not obtained from specialty vendor.
Remark	N774	Alert: Refer to your Third Party Processor Agreement for specific information on fees associated with this payment type.
Remark	N775	Payment adjusted based on x-ray radiograph on film.
Remark	N776	This service is not a covered Telehealth service.
Remark	N777	Missing Assignment of Benefits Indicator. (Modified 3/1/2017)
Remark	N778	Missing Primary Care Physician Information.
Remark	N779	Replacement/Void claims cannot be submitted until the original claim has finalized. Please resubmit once payment or denial is received.
Remark	N780	Missing/incomplete/invalid end therapy date.
Remark	N781	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer. (Modified 3/1/2018)
Remark	N782	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer. (Modified 3/1/2018)
Remark	N783	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected copayment. This amount may be billed to a subsequent payer. (Modified 3/1/2018)
Remark	N784	Missing comprehensive procedure code.
Remark	N785	Missing current radiology film/images.
Remark	N786	Benefit limitation for the orthodontic active and/or retention phase of treatment.
Remark	N787	Alert: Under 42 CFR 410.43, an eligible Partial Hospitalization Program (PHP) patient/beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be furnished in accordance with the plan of care.
Remark	N788	The third party administrator/review organization did not receive the required information. (Modified 11/1/2017)
Remark	N789	Clinical Trial is not a covered benefit.
Remark	N790	Provider/supplier not accredited for product/service.
Remark	N791	Missing history & physical report.
Remark	N792	Incomplete/invalid history & physical report.
Remark	N793	Alert: CMS is changing from the Medicare Health Insurance Claim number (HICN) to the new Medicare Beneficiary Identifier (MBI). You can use either the HICN or MBI during the transition period. Visit www.cms.gov/newcard for important dates and information about this change. (Modified 11/1/2017)
Remark	N794	Payment adjusted based on type of technology used.
Remark	N795	Item must be resubmitted as a purchase.
Remark	N796	Missing/incomplete/invalid Hemoglobin (Hb or Hgb) value.
Remark	N797	Missing/incomplete/invalid date qualifier.
Remark	N798	Submit a void request for the original claim and resubmit a new claim.
Remark	N799	Submitted identifier must be an individual identifier, not group identifier. (Modified 3/1/2018)
Remark	N800	Only one service date is allowed per claim.
Remark	N801	Services performed in a Medicare participating or CAH facility under a self-insured tribal Group Health Plan, in accordance with Federal Regulation 42 CFR 136.
Remark	N802	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Rendering Physician is located.

Type	Code	Description	
Remark	N803	Submission of the claim for the service rendered is the responsibility of the Contracted Medical Group or Hospital.	
Type	**Code**	**Description**	**Discontinued Date**
Medicaid Errors	1	Deductible Amount	
Medicaid Errors	2	Coinsurance Amount	
Medicaid Errors	3	Co-payment Amount	
Medicaid Errors	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	13	The date of death precedes the date of service.	
Medicaid Errors	14	The date of birth follows the date of service.	
Medicaid Errors	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	
Medicaid Errors	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	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.)	7/1/2009
Medicaid Errors	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	
Medicaid Errors	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	
Medicaid Errors	20	This injury/illness is covered by the liability carrier.	

Type	Code	Description	Discontinued Date
Medicaid Errors	21	This injury/illness is the liability of the no-fault carrier.	
Medicaid Errors	22	This care may be covered by another payer per coordination of benefits.	
Medicaid Errors	23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	
Medicaid Errors	24	Charges are covered under a capitation agreement/managed care plan.	
Medicaid Errors	25	Payment denied. Your Stop loss deductible has not been met.	4/1/2008
Medicaid Errors	26	Expenses incurred prior to coverage.	
Medicaid Errors	27	Expenses incurred after coverage terminated.	
Medicaid Errors	28	Coverage not in effect at the time the service was provided. Redundant to codes 26&27.	10/16/2003
Medicaid Errors	29	The time limit for filing has expired.	
Medicaid Errors	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	2/1/2006
Medicaid Errors	31	Patient cannot be identified as our insured.	
Medicaid Errors	32	Our records indicate the patient is not an eligible dependent.	
Medicaid Errors	33	Insured has no dependent coverage.	
Medicaid Errors	34	Insured has no coverage for newborns.	
Medicaid Errors	35	Lifetime benefit maximum has been reached.	
Medicaid Errors	36	Balance does not exceed co-payment amount.	10/16/2003
Medicaid Errors	37	Balance does not exceed deductible.	10/16/2003
Medicaid Errors	38	Services not provided or authorized by designated (network/primary care) providers. CARC codes 242 and 243 are replacements for this deactivated code	1/1/2013
Medicaid Errors	39	Services denied at the time authorization/pre-certification was requested.	
Medicaid Errors	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	41	Discount agreed to in Preferred Provider contract.	10/16/2003
Medicaid Errors	42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	6/1/2007
Medicaid Errors	43	Gramm-Rudman reduction.	7/1/2006
Medicaid Errors	44	Prompt-pay discount.	

Type	Code	Description	Discontinued Date
Medicaid Errors	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	
Medicaid Errors	46	This (these) service(s) is (are) not covered. Use code 96.	10/16/2003
Medicaid Errors	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	2/1/2006
Medicaid Errors	48	This (these) procedure(s) is (are) not covered. Use code 96.	10/16/2003
Medicaid Errors	49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	2/1/2006
Medicaid Errors	53	Services by an immediate relative or a member of the same household are not covered.	
Medicaid Errors	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	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. Split into codes 150, 151, 152, 153 and 154.	6/30/2007
Medicaid Errors	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	
Medicaid Errors	61	Adjusted for failure to obtain second surgical opinion The description effective date was inadvertently published as 3/1/2016 on 7/1/2016. That has been corrected to 1/1/2017.	
Medicaid Errors	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	4/1/2007
Medicaid Errors	63	Correction to a prior claim.	10/16/2003
Medicaid Errors	64	Denial reversed per Medical Review.	10/16/2003

Type	Code	Description	Discontinued Date
Medicaid Errors	65	Procedure code was incorrect. This payment reflects the correct code.	10/16/2003
Medicaid Errors	66	Blood Deductible.	
Medicaid Errors	67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	10/16/2003
Medicaid Errors	68	DRG weight. (Handled in CLP12)	10/16/2003
Medicaid Errors	69	Day outlier amount.	
Medicaid Errors	70	Cost outlier - Adjustment to compensate for additional costs.	
Medicaid Errors	71	Primary Payer amount. Use code 23.	6/30/2000
Medicaid Errors	72	Coinsurance day. (Handled in QTY, QTY01=CD)	10/16/2003
Medicaid Errors	73	Administrative days.	10/16/2003
Medicaid Errors	74	Indirect Medical Education Adjustment.	
Medicaid Errors	75	Direct Medical Education Adjustment.	
Medicaid Errors	76	Disproportionate Share Adjustment.	
Medicaid Errors	77	Covered days. (Handled in QTY, QTY01=CA)	10/16/2003
Medicaid Errors	78	Non-Covered days/Room charge adjustment.	
Medicaid Errors	79	Cost Report days. (Handled in MIA15)	10/16/2003
Medicaid Errors	80	Outlier days. (Handled in QTY, QTY01=OU)	10/16/2003
Medicaid Errors	81	Discharges.	10/16/2003
Medicaid Errors	82	PIP days.	10/16/2003
Medicaid Errors	83	Total visits.	10/16/2003
Medicaid Errors	84	Capital Adjustment. (Handled in MIA)	10/16/2003
Medicaid Errors	85	Patient Interest Adjustment (Use Only Group code PR) Only use when the payment of interest is the responsibility of the patient.	
Medicaid Errors	86	Statutory Adjustment. Duplicative of code 45.	10/16/2003
Medicaid Errors	87	Transfer amount.	1/1/2012
Medicaid Errors	88	Adjustment amount represents collection against receivable created in prior overpayment.	6/30/2007
Medicaid Errors	89	Professional fees removed from charges.	
Medicaid Errors	90	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.	

Type	Code	Description	Discontinued Date
Medicaid Errors	91	Dispensing fee adjustment.	
Medicaid Errors	92	Claim Paid in full.	10/16/2003
Medicaid Errors	93	No Claim level Adjustments. As of 004010, CAS at the claim level is optional.	10/16/2003
Medicaid Errors	94	Processed in Excess of charges.	
Medicaid Errors	95	Plan procedures not followed.	
Medicaid Errors	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	98	The hospital must file the Medicare claim for this inpatient non-physician service.	10/16/2003
Medicaid Errors	99	Medicare Secondary Payer Adjustment Amount.	10/16/2003
Medicaid Errors	100	Payment made to patient/insured/responsible party/employer. Effective 05/01/2018: Payment made to patient/insured/responsible party.	
Medicaid Errors	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	
Medicaid Errors	102	Major Medical Adjustment.	
Medicaid Errors	103	Provider promotional discount (e.g., Senior citizen discount).	
Medicaid Errors	104	Managed care withholding.	
Medicaid Errors	105	Tax withholding.	
Medicaid Errors	106	Patient payment option/election not in effect.	
Medicaid Errors	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	
Medicaid Errors	110	Billing date predates service date.	
Medicaid Errors	111	Not covered unless the provider accepts assignment.	
Medicaid Errors	112	Service not furnished directly to the patient and/or not documented.	
Medicaid Errors	113	Payment denied because service/procedure was provided outside the United States or as a result of war. Use Codes 157, 158 or 159.	6/30/2007
Medicaid Errors	114	Procedure/product not approved by the Food and Drug Administration.	

Type	Code	Description	Discontinued Date
Medicaid Errors	115	Procedure postponed, canceled, or delayed.	
Medicaid Errors	116	The advance indemnification notice signed by the patient did not comply with requirements.	
Medicaid Errors	117	Transportation is only covered to the closest facility that can provide the necessary care.	
Medicaid Errors	118	ESRD network support adjustment.	
Medicaid Errors	119	Benefit maximum for this time period or occurrence has been reached.	
Medicaid Errors	120	Patient is covered by a managed care plan. Use code 24.	6/30/2007
Medicaid Errors	121	Indemnification adjustment - compensation for outstanding member responsibility.	
Medicaid Errors	122	Psychiatric reduction.	
Medicaid Errors	123	Payer refund due to overpayment. Refer to implementation guide for proper handling of reversals.	6/30/2007
Medicaid Errors	124	Payer refund amount - not our patient. Refer to implementation guide for proper handling of reversals.	6/30/2007
Medicaid Errors	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.)	11/1/2013
Medicaid Errors	126	Deductible -- Major Medical Use Group Code PR and code 1.	4/1/2008
Medicaid Errors	127	Coinsurance -- Major Medical Use Group Code PR and code 2.	4/1/2008
Medicaid Errors	128	Newborn's services are covered in the mother's Allowance.	
Medicaid Errors	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.)	
Medicaid Errors	130	Claim submission fee.	
Medicaid Errors	131	Claim specific negotiated discount.	
Medicaid Errors	132	Prearranged demonstration project adjustment.	
Medicaid Errors	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	
Medicaid Errors	134	Technical fees removed from charges.	
Medicaid Errors	135	Interim bills cannot be processed.	
Medicaid Errors	136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	
Medicaid Errors	137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	
Medicaid Errors	138	Appeal procedures not followed or time limits not met.	

Type	Code	Description	Discontinued Date
Medicaid Errors	139	Contracted funding agreement - Subscriber is employed by the provider of services. Effective 05/01/2018: Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	
Medicaid Errors	140	Patient/Insured health identification number and name do not match.	
Medicaid Errors	141	Claim spans eligible and ineligible periods of coverage.	7/1/2012
Medicaid Errors	142	Monthly Medicaid patient liability amount.	
Medicaid Errors	143	Portion of payment deferred.	
Medicaid Errors	144	Incentive adjustment, e.g. preferred product/service.	
Medicaid Errors	145	Premium payment withholding Use Group Code CO and code 45.	4/1/2008
Medicaid Errors	146	Diagnosis was invalid for the date(s) of service reported.	
Medicaid Errors	147	Provider contracted/negotiated rate expired or not on file.	
Medicaid Errors	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.)	
Medicaid Errors	149	Lifetime benefit maximum has been reached for this service/benefit category.	
Medicaid Errors	150	Payer deems the information submitted does not support this level of service.	
Medicaid Errors	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	
Medicaid Errors	152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	153	Payer deems the information submitted does not support this dosage.	
Medicaid Errors	154	Payer deems the information submitted does not support this day's supply.	
Medicaid Errors	155	Patient refused the service/procedure.	
Medicaid Errors	156	Flexible spending account payments. Note: Use code 187.	10/1/2009
Medicaid Errors	157	Service/procedure was provided as a result of an act of war.	
Medicaid Errors	158	Service/procedure was provided outside of the United States.	
Medicaid Errors	159	Service/procedure was provided as a result of terrorism.	
Medicaid Errors	160	Injury/illness was the result of an activity that is a benefit exclusion.	
Medicaid Errors	161	Provider performance bonus	
Medicaid Errors	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. Use code P1	7/1/2014

Type	Code	Description	Discontinued Date
Medicaid Errors	163	Attachment/other documentation referenced on the claim was not received.	
Medicaid Errors	164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	
Medicaid Errors	165	Referral absent or exceeded.	
Medicaid Errors	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	
Medicaid Errors	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	
Medicaid Errors	169	Alternate benefit has been provided.	
Medicaid Errors	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	173	Service/equipment was not prescribed by a physician.	
Medicaid Errors	174	Service was not prescribed prior to delivery.	
Medicaid Errors	175	Prescription is incomplete.	
Medicaid Errors	176	Prescription is not current.	
Medicaid Errors	177	Patient has not met the required eligibility requirements.	
Medicaid Errors	178	Patient has not met the required spend down requirements.	
Medicaid Errors	179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	180	Patient has not met the required residency requirements.	
Medicaid Errors	181	Procedure code was invalid on the date of service.	
Medicaid Errors	182	Procedure modifier was invalid on the date of service.	
Medicaid Errors	183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	

Type	Code	Description	Discontinued Date
Medicaid Errors	186	Level of care change adjustment.	
Medicaid Errors	187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	
Medicaid Errors	188	This product/procedure is only covered when used according to FDA recommendations.	
Medicaid Errors	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	
Medicaid Errors	190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	
Medicaid Errors	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) Use code P2	7/1/2014
Medicaid Errors	192	Non standard adjustment code from paper remittance. Usage: 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.	
Medicaid Errors	193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	
Medicaid Errors	194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	
Medicaid Errors	195	Refund issued to an erroneous priority payer for this claim/service.	
Medicaid Errors	196	Claim/service denied based on prior payer's coverage determination. Use code 136.	2/1/2007
Medicaid Errors	197	Precertification/authorization/notification absent. Effective 05/01/2018: Precertification/authorization/notification/pre-treatment absent.	
Medicaid Errors	198	Precertification/authorization exceeded. Effective 05/01/2018: Precertification/notification/authorization/pre-treatment exceeded.	
Medicaid Errors	199	Revenue code and Procedure code do not match.	
Medicaid Errors	200	Expenses incurred during lapse in coverage	
Medicaid Errors	201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) 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.) Not for use by Workers' Compensation payers; use code P3 instead.	
Medicaid Errors	202	Non-covered personal comfort or convenience services.	
Medicaid Errors	203	Discontinued or reduced service.	
Medicaid Errors	204	This service/equipment/drug is not covered under the patient’s current benefit plan	
Medicaid Errors	205	Pharmacy discount card processing fee	
Medicaid Errors	206	National Provider Identifier - missing.	

Type	Code	Description	Discontinued Date
Medicaid Errors	207	National Provider identifier - Invalid format	
Medicaid Errors	208	National Provider Identifier - Not matched.	
Medicaid Errors	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 only with Group code OA)	
Medicaid Errors	210	Payment adjusted because pre-certification/authorization not received in a timely fashion	
Medicaid Errors	211	National Drug Codes (NDC) not eligible for rebate, are not covered.	
Medicaid Errors	212	Administrative surcharges are not covered	
Medicaid Errors	213	Non-compliance with the physician self referral prohibition legislation or payer policy.	
Medicaid Errors	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 Use code P4	7/1/2014
Medicaid Errors	215	Based on subrogation of a third party settlement	
Medicaid Errors	216	Based on the findings of a review organization	
Medicaid Errors	217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only) Use code P5	7/1/2014
Medicaid Errors	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 Use code P6	7/1/2014
Medicaid Errors	219	Based on extent of injury. Usage: 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).	
Medicaid Errors	220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only) Use code P7	7/1/2014
Medicaid Errors	221	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). (Note: To be used by Property & Casualty only) Use code P8	7/1/2014
Medicaid Errors	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	

Type	Code	Description	Discontinued Date
Medicaid Errors	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.	
Medicaid Errors	224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	
Medicaid Errors	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)	
Medicaid Errors	226	Information requested from the Billing/Rendering Provider was not provided or not provided timely 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.)	
Medicaid Errors	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.)	
Medicaid Errors	228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	
Medicaid Errors	229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Usage: 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 only with Group Code PR)	
Medicaid Errors	230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty. Use code P9	7/1/2014
Medicaid Errors	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	232	Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	
Medicaid Errors	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	
Medicaid Errors	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.)	
Medicaid Errors	235	Sales Tax	
Medicaid Errors	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 or workers compensation state regulations/ fee schedule requirements.	
Medicaid Errors	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.)	
Medicaid Errors	238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	
Medicaid Errors	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	
Medicaid Errors	240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	241	Low Income Subsidy (LIS) Co-payment Amount	
Medicaid Errors	242	Services not provided by network/primary care providers. This code replaces deactivated code 38	

Type	Code	Description	Discontinued Date
Medicaid Errors	243	Services not authorized by network/primary care providers. This code replaces deactivated code 38	
Medicaid Errors	244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only. Use code P10	7/1/2014
Medicaid Errors	245	Provider performance program withhold.	
Medicaid Errors	246	This non-payable code is for required reporting only.	
Medicaid Errors	247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).	
Medicaid Errors	248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).	
Medicaid Errors	249	This claim has been identified as a readmission. (Use only with Group Code CO)	
Medicaid Errors	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	
Medicaid Errors	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	
Medicaid Errors	252	An attachment/other documentation is required to adjudicate this claim/service. 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).	
Medicaid Errors	253	Sequestration - reduction in federal payment	
Medicaid Errors	254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration. Use CARC 290 if the claim was forwarded.	
Medicaid Errors	255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA) Use code P11	7/1/2014
Medicaid Errors	256	Service not payable per managed care contract.	
Medicaid Errors	257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) To be used after the first month of the grace period.	
Medicaid Errors	258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	
Medicaid Errors	259	Additional payment for Dental/Vision service utilization.	
Medicaid Errors	260	Processed under Medicaid ACA Enhanced Fee Schedule	
Medicaid Errors	261	The procedure or service is inconsistent with the patient's history.	
Medicaid Errors	262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.	
Medicaid Errors	263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.	

Type	Code	Description	Discontinued Date
Medicaid Errors	264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only.	
Medicaid Errors	265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	
Medicaid Errors	266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	
Medicaid Errors	267	Claim/service spans multiple months. 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.)	
Medicaid Errors	268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	
Medicaid Errors	269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient’s dental plan for further consideration. Use CARC 291 if the claim was forwarded.	
Medicaid Errors	271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)	
Medicaid Errors	272	Coverage/program guidelines were not met.	
Medicaid Errors	273	Coverage/program guidelines were exceeded.	
Medicaid Errors	274	Fee/Service not payable per patient Care Coordination arrangement.	
Medicaid Errors	275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	
Medicaid Errors	276	Services denied by the prior payer(s) are not covered by this payer.	
Medicaid Errors	277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) To be used during 31 day SHOP grace period.	
Medicaid Errors	278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.	
Medicaid Errors	280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration. Use CARC 292 if the claim was forwarded.	
Medicaid Errors	281	Deductible waived per contractual agreement. Use only with Group Code CO.	
Medicaid Errors	282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	283	Attending provider is not eligible to provide direction of care.	
Medicaid Errors	284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	

Type	Code	Description	Discontinued Date
Medicaid Errors	285	Appeal procedures not followed	
Medicaid Errors	286	Appeal time limits not met	
Medicaid Errors	287	Referral exceeded	
Medicaid Errors	288	Referral absent	
Medicaid Errors	289	Services considered under the dental and medical plans, benefits not available. Also see CARCs 254, 270 and 280.	
Medicaid Errors	290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration. Use CARC 254 if the claim was not forwarded.	
Medicaid Errors	291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration. Use CARC 270 if the claim was not forwarded.	
Medicaid Errors	292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration. Use CARC 280 if the claim was not forwarded.	
Medicaid Errors	293	Payment made to employer.	
Medicaid Errors	294	Payment made to attorney.	
Medicaid Errors	295	Pharmacy Direct/Indirect Remuneration (DIR)	
Medicaid Errors	A0	Patient refund amount.	
Medicaid Errors	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.)	
Medicaid Errors	A2	Contractual adjustment. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.	1/1/2008
Medicaid Errors	A3	Medicare Secondary Payer liability met.	10/16/2003
Medicaid Errors	A4	Medicare Claim PPS Capital Day Outlier Amount.	4/1/2008
Medicaid Errors	A5	Medicare Claim PPS Capital Cost Outlier Amount.	
Medicaid Errors	A6	Prior hospitalization or 30 day transfer requirement not met.	
Medicaid Errors	A7	Presumptive Payment Adjustment	7/1/2015
Medicaid Errors	A8	Ungroupable DRG.	
Medicaid Errors	B1	Non-covered visits.	
Medicaid Errors	B2	Covered visits.	10/16/2003
Medicaid Errors	B3	Covered charges.	10/16/2003
Medicaid Errors	B4	Late filing penalty.	

Type	Code	Description	Discontinued Date
Medicaid Errors	B5	Coverage/program guidelines were not met or were exceeded. This code has been replaced by 272 and 273.	5/1/2016
Medicaid Errors	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.	2/1/2006
Medicaid Errors	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	B9	Patient is enrolled in a Hospice.	
Medicaid Errors	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.	
Medicaid Errors	B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	
Medicaid Errors	B12	Services not documented in patient's medical records.	
Medicaid Errors	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	
Medicaid Errors	B14	Only one visit or consultation per physician per day is covered.	
Medicaid Errors	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
Medicaid Errors	B16	'New Patient' qualifications were not met.	
Medicaid Errors	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.	2/1/2006
Medicaid Errors	B18	This procedure code and modifier were invalid on the date of service.	3/1/2009
Medicaid Errors	B19	Claim/service adjusted because of the finding of a Review Organization.	10/16/2003
Medicaid Errors	B20	Procedure/service was partially or fully furnished by another provider.	
Medicaid Errors	B21	The charges were reduced because the service/care was partially furnished by another physician.	10/16/2003
Medicaid Errors	B22	This payment is adjusted based on the diagnosis.	
Medicaid Errors	B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	
Medicaid Errors	D1	Claim/service denied. Level of subluxation is missing or inadequate. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D2	Claim lacks the name, strength, or dosage of the drug furnished. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D4	Claim/service does not indicate the period of time for which this will be needed. Use code 16 and remark codes if necessary.	10/16/2003

Type	Code	Description	Discontinued Date
Medicaid Errors	D5	Claim/service denied. Claim lacks individual lab codes included in the test. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D6	Claim/service denied. Claim did not include patient's medical record for the service. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.' Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	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. Use code 16 and remark codes if necessary.	10/16/2003
Medicaid Errors	D10	Claim/service denied. Completed physician financial relationship form not on file. Use code 17.	10/16/2003
Medicaid Errors	D11	Claim lacks completed pacemaker registration form. Use code 17.	10/16/2003
Medicaid Errors	D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. Use code 17.	10/16/2003
Medicaid Errors	D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. Use code 17.	10/16/2003
Medicaid Errors	D14	Claim lacks indication that plan of treatment is on file. Use code 17.	10/16/2003
Medicaid Errors	D15	Claim lacks indication that service was supervised or evaluated by a physician. Use code 17.	10/16/2003
Medicaid Errors	D16	Claim lacks prior payer payment information. Use code 16 with appropriate claim payment remark code [N4].	6/30/2007
Medicaid Errors	D17	Claim/Service has invalid non-covered days. Use code 16 with appropriate claim payment remark code.	6/30/2007
Medicaid Errors	D18	Claim/Service has missing diagnosis information. Use code 16 with appropriate claim payment remark code.	6/30/2007
Medicaid Errors	D19	Claim/Service lacks Physician/Operative or other supporting documentation Use code 16 with appropriate claim payment remark code.	6/30/2007
Medicaid Errors	D20	Claim/Service missing service/product information. Use code 16 with appropriate claim payment remark code.	6/30/2007
Medicaid Errors	D21	This (these) diagnosis(es) is (are) missing or are invalid	6/30/2007
Medicaid Errors	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	1/1/2009
Medicaid Errors	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.)	1/1/2012
Medicaid Errors	P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only. This code replaces deactivated code 162	
Medicaid Errors	P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: 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. This code replaces deactivated code 191	

Type	Code	Description	Discontinued Date
Medicaid Errors	P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR) This code replaces deactivated code 201	
Medicaid Errors	P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: 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 This code replaces deactivated code 214	
Medicaid Errors	P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only. This code replaces deactivated code 217	
Medicaid Errors	P6	Based on entitlement to benefits. Usage: 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 Property and Casualty only. This code replaces deactivated code 218	
Medicaid Errors	P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only. This code replaces deactivated code 220	
Medicaid Errors	P8	Claim is under investigation. Usage: 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 Property and Casualty only. This code replaces deactivated code 221	
Medicaid Errors	P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only. This code replaces deactivated code 230	
Medicaid Errors	P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only. This code replaces deactivated code 244	
Medicaid Errors	P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA) This code replaces deactivated code 255	
Medicaid Errors	P12	Workers' compensation jurisdictional fee schedule adjustment. Usage: 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) if the regulations apply. To be used for Workers' Compensation only. This code replaces deactivated code W1	
Medicaid Errors	P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Workers' Compensation only. This code replaces deactivated code W2	

Type	Code	Description	Discontinued Date
Medicaid Errors	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only. This code replaces deactivated code W3	
Medicaid Errors	P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only. This code replaces deactivated code W4	
Medicaid Errors	P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA) This code replaces deactivated code W5	
Medicaid Errors	P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only. This code replaces deactivated code W6	
Medicaid Errors	P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only. This code replaces deactivated code W7	
Medicaid Errors	P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only. This code replaces deactivated code W8	
Medicaid Errors	P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only. This code replaces deactivated code W9	
Medicaid Errors	P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only. This code replaces deactivated code Y1	
Medicaid Errors	P22	Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only. This code replaces deactivated code Y2	
Medicaid Errors	P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Usage: 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) if the regulations apply. To be used for Property and Casualty Auto only. This code replaces deactivated code Y3	
Medicaid Errors	P24	Payment adjusted based on Preferred Provider Organization (PPO). Usage: 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) if the regulations apply. To be used for Property and Casualty only. Use only with Group Code CO.	

Type	Code	Description	Discontinued Date
Medicaid Errors	P25	Payment adjusted based on Medical Provider Network (MPN). Usage: 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) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).	
Medicaid Errors	P26	Payment adjusted based on Voluntary Provider network (VPN). Usage: 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) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).	
Medicaid Errors	P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.	
Medicaid Errors	P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.	
Medicaid Errors	P29	Liability Benefits jurisdictional fee schedule adjustment. Usage: 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) if the regulations apply. To be used for Property and Casualty Auto only.	
Medicaid Errors	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) if the regulations apply. Use code P12	7/1/2014
Medicaid Errors	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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Workers' Compensation only. Use code P13	7/1/2014
Medicaid Errors	W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only. Use code P14	7/1/2014
Medicaid Errors	W4	Workers' Compensation Medical Treatment Guideline Adjustment. Use code P15	7/1/2014
Medicaid Errors	W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA) Use code P16	7/1/2014

Type	Code	Description	Discontinued Date
Medicaid Errors	W6	Referral not authorized by attending physician per regulatory requirement. Use code P17	7/1/2014
Medicaid Errors	W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. Use code P18	7/1/2014
Medicaid Errors	W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. Use code P19	7/1/2014
Medicaid Errors	W9	Service not paid under jurisdiction allowed outpatient facility fee schedule. Use code P20	7/1/2014
Medicaid Errors	Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for P&C Auto only. Use code P21	7/1/2014
Medicaid Errors	Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for P&C Auto only. Use code P22	7/1/2014
Medicaid Errors	Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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) if the regulations apply. To be used for P&C Auto only. Use code P23	7/1/2014