MEDICARE PART A BULLETIN

January 15, 1997 General Medicare Bulletin G-259

TO: All Medicare Providers

FROM: Andy DePirro, Director Program Relations

SUBJECT: **UPDATED LIST OF MEDICARE APPROVED (ANSI) REASON CODES, REMARK CODES, AND MESSAGE CODES UTILIZED ON REMITTANCE ADVICE NOTICES**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to the appropriate health care facility personnel.

The Health Care Financing Administration (HCFA) mandated the use of a standard paper remittance advice for all Medicare Contractors (intermediaries and carriers), effective October 2, 1995. Blue Cross and Blue Shield of Florida, Inc. implemented the standard paper remittance advice during January, 1996. Please reference General Medicare Bulletin G-202, published December 27, 1995 for more information (e.g., Standard Paper Remittance layout). The purpose of this bulletin is to publish an updated list of all Medicare-approved reason codes, Medicare-specific remark codes, and messages that are utilized on the electronic and standard paper remittance notices. The codes provided via this bulletin attachment supersede codes published in General Medicare Bulletin G-202.

REASON CODES AND MEDICARE-SPECIFIC REMARKS CODES AND MESSAGES

Reason codes, and the text messages that define those codes, are used to **explain why a claim may not have been paid in full.** For instance, there are reason codes to indicate that a particular service is never covered by Medicare, to identify non-payable charges which exceed the fee schedule, etc. Under the standard format, only reason codes approved by the ANSI X12.835 Insurance Subcommittee, and Medicare-specific supplemental messages approved by HCFA, are allowed.

NOTE: The five-digit reason code assigned by the Florida Shared System (FSS) is replaced by the approved ANSI X12.835 reason codes.

Providers who utilize the Direct Data Entry (DDE) system are able to access the claim on-line and obtain the five-digit FSS reason code that was assigned. The five-digit FSS reason code is reflected on all reports generated by the Fiscal Intermediary (FI) with the exception of the Standard Paper Remittance Advice.

Any questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.

MEDICARE REMARK CODES

Remark codes are utilized to relay service-specific Medicare informational messages concerning the processing of the claim. Under the standard paper remittance advice format, only Medicare remark codes approved by HCFA are allowed.

Code Value	Description
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
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.
M6	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 every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased.
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.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases are limited to the first or the thirteenth month of medical necessity.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.
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.
M15	Separately billed services have been bundled under a single procedure code as they are considered components of that same procedure. Separate payment is not allowed.
M16	Please see the letter or bulletin of (date) for further information.
M17	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.
M18	Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.
M19	Oxygen certification/recertification (HCFA-484) is incomplete.
M20	HCPCS needed.
M21	Claim for services/items provided in a home must indicate the place of residence.
M22	Claim lacks the number of miles traveled.
M23	Invoice needed for the cost of the material or contrast agent.
M24	Claim must indicate the number of doses per vial.

Code Value	Description
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) 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 (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/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 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 review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within the 30-day period, 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 tomake any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in §1842(l) 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. Please contact this office if you have any questions about this notice.

Code Value	Description
M27	The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary'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 provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Claim lacks the operative report.
M30	Claim lacks the pathology report.
M31	Claim lacks the radiology report.
M32	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.
M33	Claim lacks the UPIN of the ordering/referring or performing physician, or the UPIN is invalid.
M34	Claim lacks the CLIA certification number.
M35	Claim lacks pre-operative photos or visual field results.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37	Service not covered when the beneficiary is under age 35.
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.
M43	Reserved for future use
M44	Incomplete/invalid condition code.
M45	Incomplete/invalid occurrence codes and dates.
M46	Incomplete/invalid occurrence span code and dates.

Code Value	Description
M47	Incomplete/invalid internal or document control number.
M48	Reserved for future use
M49	Incomplete/invalid value code(s) and/or amount(s).
M50	Incomplete/invalid revenue code(s).
M51	Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes. Refer to the HCFA Common Procedure Coding System.
M52	Incomplete/invalid "from" date(s) of service.
M53	Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
M54	Did not complete or enter the correct total charges for services rendered.
M55	Reserved for future use
M56	Incomplete/invalid payer identification.
M57	Incomplete/invalid provider number.
M58	Please resubmit the claim with the missing/correct information so that it may be processed.
M59	Incomplete/invalid "to" date(s) of service.
M60	Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed,EOMB-approved form or in an approved format.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Incomplete/invalid treatment authorization code.
M63	Reserved for future use
M64	Incomplete/invalid other diagnosis code.
M65	Only one technical component can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each technical component code.
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.
M67	Incomplete/invalid other procedure code(s) and/or date(s).
M68	Incomplete/invalid attending or referring physician identification.
M69	Paid at the regular rate as you did not submit documentation to justify modifier 22.
M70	NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item.
M71-75	Reserved for future use
M76	Incomplete/invalid patient's diagnosis(es) and condition(s).
M77	Incomplete/invalid place of service(s).
M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79	Did not complete or enter the appropriate charge for each listed service.
M80	We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.
M81	Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82	And higher reserved for future use

MEDICARE REASON CODES

The following **REASON CODES** will be used to return a claim that is unprocessable, rejected/ denied, and/or to advice why the claim was partially paid or the payment reduced. Note: These reason codes will be reflected on the standard paper remittance advice instead of the five-digit reason codes generated by the Florida Shared System (FSS) and will be reflected in the "RC" field if applicable:

Code Value	Description
MA01	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 review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. (An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)
MA03	If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance) , you may ask for a hearing. You must request 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 reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. (An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)
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.
MA05	Incorrect admission date, patient status or type of bill entry on claim. (NOTE: See MA30, MA40 and MA43 also.)
MA06	Incorrect beginning and/or ending date(s) on claim.
MA07	The claim information has also been forwarded to Medicaid for review.

Code Value	Description
MA08	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
MA10	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
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.
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).
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.
MA14	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.
MA15	Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
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.
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.
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	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.
MA20	SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.
MA22	Payment of less than $1.00 suppressed.
MA23	Demand bill approved as result of medical review.
MA24	Christian Science Sanitorium/ SNF bill in the same benefit period.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Our records indicate that you were previously informed of this rule.
MA27	Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.

Code Value	Description
MA28	Receipt of this notice by a physician who did not accept assignment is for information only and does not make the physician 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.
MA29	Incomplete/invalid provider name, city, state, and zip code.
MA30	Incomplete/invalid type of bill.
MA31	Incomplete/invalid beginning and ending dates of the period billed.
MA32	Incomplete/invalid number of covered days during the billing period.
MA33	Incomplete/invalid number of noncovered days during the billing period.
MA34	Incomplete/invalid number of coinsurance days during the billing period.
MA35	Incomplete/invalid number of lifetime reserve days.
MA36	Incomplete/invalid patient's name.
MA37	Incomplete/invalid patient's address.
MA38	Incomplete/invalid patient's birth date.
MA39	Incomplete/invalid patient's sex.
MA40	Incomplete/invalid admission date.
MA41	Incomplete/invalid type of admission.
MA42	Incomplete/invalid source of admission.
MA43	Incomplete/invalid patient status.
MA44-MA47	Reserved for future use
MA48	Incomplete/invalid name and/or address of responsible party.
MA49-MA57	Reserved for future use
MA58	Incomplete release of information indicator.
MA59	The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60	Incomplete/invalid patient's relationship to insured.
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62	Telephone review decision
MA63	Incomplete/invalid principal diagnosis code.
MA64	Our records indicate that Medicare 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.
MA65	Incomplete/invalid admitting diagnosis.
MA66	Incomplete/invalid principal procedure code and/or date.
MA67	Correction to a prior claim.
MA68	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.
MA69	Incomplete/invalid remarks.
MA70	Incomplete provider representative signature.
MA71	Incomplete/invalid provider representative signature date.

Code Value	Description
MA72	The beneficiary overpaid you for these assigned services. You must issue the beneficiary 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 beneficiary on this notice.
MA73	Informational remittance associated with the Medicare Choices demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75	Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
MA76	Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.
MA77	The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary's payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.
MA78	The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.
MA79	Reserved for future use.
MA80	Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81	Our records indicate neither a physician or supplier signature is on the claim or on file.
MA82	Did not complete or enter the correct physician/supplier's Medicare number or billing name, address, city, state, zip code, and phone number.
MA83	Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
MA84	Reserved for future use.
MA85	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the primary payer's PAYERID, or their plan or program name.
MA86	Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.
MA87	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.
MA88	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.
MA89	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.
MA90	Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the insured.
MA91	Reserved for future use.
MA92	Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.

Code Value	Description
MA93	Reserved for future use.
MA94	Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.
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.
MA96	Claim rejected. Coded as Medicare Choices but patient is not enrolled in a Medicare Choices HMO
MA97	Claim rejected. Does not contain the Medicare Choices HMO contract number, however, the beneficiary is enrolled in a Choices HMO.
MA98	Claim rejected. Does not contain the correct Medicare Choices HMO contract number for this beneficiary.
MA99	Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.
MA100	Did not complete or enter accurately the date of current illness, injury or pregnancy.
MA101	Reserved for future use
MA102	Did not complete or enter accurately the referring/ordering/supervising physician's name and/or their UPIN/NPI (or surrogate).
MA103	Reserved for future use
MA104	Did not complete or enter accurately the date the patient was last seen and/or the UPIN/NPI of their attending physician.
MA105-109	Reserved for future use
MA110	Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Our records indicate that the performing physician/supplier is a member of a group practice; however, you did not complete or enter accurately their carrier assigned UPIN/NPI.
MA113	Reserved for future use
MA114	Did not complete or enter accurately the name and address, or the carrier assigned UPIN/NPI, of the entity where services were furnished.
MA115	Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or UPIN/NPI) where the service(s) were rendered.
MA116	Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
MA117-120	Reserved for future use
MA121	Did not complete or enter accurately the date the X-Ray was performed.

Code Value	Description
MA122	Did not complete or enter accurately the initial date "actual" treatment occurred.
MA123	127 Reserved for future use
MA128	Did not complete or enter accurately the six digit FDA approved, identification number.
MA129	Reserved for future use
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate fiscal intermediary or carrier.
MA13	and higher Reserved for future use

MESSAGE CODES

These message codes explain the claim financial adjustments, such as denials, reductions or increases in payment, and were developed for use by all United States health care claim payers. As a result, there are a number of codes that do not apply to Medicare. The codes will be reflected in the "RC" field of the Standard Paper Remittance Advice, if applicable:

Code	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's sex.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's sex.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Claim/service denied because the authorization number is missing or invalid.
16	Claim/service lacks information which is needed for adjudication.
17	Claim/service denied because requested information was not provided or was insufficient/ incomplete.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury and thus the liability of the Worker's Com pensation carrier.
20	Claim denied because this injury is covered by the liability carrier.
21	Claim denied because this injury is the liability of the no-fault carrier.
22	Claim denied because this care may be covered by another payer per coordination of benefits.
23	Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits.

Code	Description
24	Payment for charges denied. Charges are covered under a capitation agreement.
25	Charges denied. Your stop loss deductible has not been met (not Medicare).
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
30	Benefits are not available for these services until the patient has met the required waiting or residency period.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined (not Medicare).
33	Claim denied. Insured has no dependent coverage (not Medicare).
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
36	Inactive.
37	Inactive.
38	Services not provided or authorized by our providers.
39	Services denied at the time authorization was requested.
40	Charges do not meet qualifications for emergency/urgent care out-of-area.
41	Inactive.
42	Charges exceed out fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount (not Medicare).
45	Charges exceed your contracted/legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) (are) is not covered.
48	This (these) procedure(s) (are) is not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a “medical necessity” by the payer.
51	These are non-covered services because this is a pre-existing condition (not Medicare).
52	The referring/prescribing provider is not eligible to refer/prescribe/order the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because the procedure or treatment has not been deemed “proven to be effective” by the payer.
57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service or this dosage.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges reduced as penalty for failure to obtain second surgical opinion (not Medicare).

Code	Description
62	Penalty taken for absence of pre-certification (not Medicare).
63	Inactive.
64	Inactive.
65	Inactive.
66	Blood deductible.
67	Inactive.
68	Inactive.
69	Day outlier amount.
70	Cost outlier amount.
71	Primary payer amount.
72	Inactive.
73	Inactive.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Inactive.
78	Non-covered days/room charge adjustment.
79	Inactive.
80	Inactive.
81	Inactive.
82	Inactive.
83	Inactive.
84	Inactive.
85	Interest amount.
86	Statutory adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment (not Medicare).
91	Dispensing fee adjustment (not Medicare).
92	Inactive.
93	No claim level adjustments.
94	Processed in excess of charges.
95	Benefits reduced. Plan procedures not followed.
96	Non-covered charges.
97	Payment is included in the allowance for the basic service/procedure.
98	Inactive.
99	Inactive.
100	Payment made to patient/insured/responsible party.
101	Predetermination, anticipated payment upon completion of services (not Medicare).
102	Major medical adjustment (not Medicare).
103	Provider promotional discount (i.e., senior citizen discount). (Not Medicare).
104	Managed care withholding.
105	Tax withholding (not Medicare).
106	Patient payment option/election not in effect.

Code	Description
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Claim/service denied/reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Claim/service denied/reduced as not furnished directly to the patient and/or not documented.
113	Claim denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Claim/service denied/reduced as procedure postponed or canceled.
116	Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
125	Claim/service denied/reduced due to a submission/billing error.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	Medicare Secondary Payer patient liability met.
A4	Medicare day claim PPS capital outlier amount.
A5	Medicare cost claim PPS capital outlier amount.
A6	Prior hospitalization or 30-day transfer requirement not met.
A7	Presumptive payment adjustment.
B1	Non-covered visits.
B2	Covered visits.
B3	Covered charges.
B4	Late filing penalty.
B5	Claim/service denied/reduced because coverage guidelines were not met or were exceeded.
B6	This service/procedure is denied/reduced when performed/billed by this type of provider, by type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a hospice.

Code	Description
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.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/ service not covered by this payer/processor.
B12	Services not documented in patient's medical records.
B13	Payment is included in the payment already made.
B14	Claim/service denied because only one visit or consultation per physician per day is covered.
B15	Claim/service denied/reduced because this procedure/service is not paid separately.
B16	Claim/service denied/reduced because "New Patient" qualifications were not met.
B17	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	Claim/service denied/reduced because of the finding of a review organization.
B20	Charges denied/reduced because procedure/service was partially or fully furnished by another provider.
B21	Inactive
B22	This claim/service is denied/reduced based on the diagnosis.
B23	Claim/service denied because this provider has failed an aspect of a proficiency testing program.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength, or dosage of the drug furnished.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that "x-ray is available for review."
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.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.