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/revenue code is inconsistent with the patient's age. *Note: Changed as of 6/02*
7	The procedure/revenue code is inconsistent with the patient's gender. *Note: Changed as of 6/02*
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). *Note: Changed as of 6/02*
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender. *Note: Changed as of 2/00*
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	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed se provider. *Note: Changed as of 2/01*
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be prov (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) *Note: Changed as of 2/02 and 6/06*
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional inform supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Rej Reason Code.) *Note: Changed as of 2/02 and 6/06*
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits. *Note: Changed as of 2/01*
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments *Note: Changed as of 2/01, and 6/05*
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. *Note: Changed as of 6/00*
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided. *Note: Inactive for 004010, since 6/98. Redundant to codes 26&27.*
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency require *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
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.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached. *Note: Changed as of 10/02*
36	Balance does not exceed co-payment amount.

Note: Inactive for 003040

37	Balance does not exceed deductible. *Note: Inactive for 003040*
38	Services not provided or authorized by designated (network/primary care) providers. *Note: Changed as of 6/03*
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	Discount agreed to in Preferred Provider contract. *Note: Inactive for 003040*
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction. *Note: Changed as of 6/06. This code will be deactivated on 7/1/2006.*
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
46	This (these) service(s) is (are) not covered. *Note: Inactive for 004010, since 6/00. Use code 96.*
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. *Note: Changed as of 6/00. This code will be deactivated on 2/1/2006.*
48	This (these) procedure(s) is (are) not covered. *Note: Inactive for 004010, since 6/00. Use code 96.*
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a ro 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
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. *Note: Changed as of 10/98. This code will be deactivated on 2/1/2006.*
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 procedure/treatment has not been deemed `proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, many services, this length of service, this dosage, or this day's supply. *Note: Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.*
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid service. *Note: Changed as of 2/01*
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. *Note: Changed as of 6/00*
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion. *Note: Changed as of 6/00*
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. *Note: Changed as of 2/01*
63	Correction to a prior claim. *Note: Inactive for 003040*
64	Denial reversed per Medical Review. *Note: Inactive for 003040*
65	Procedure code was incorrect. This payment reflects the correct code. *Note: Inactive for 003040*
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA) *Note: Inactive for 003040*
68	DRG weight. (Handled in CLP12) *Note: Inactive for 003040*
69	Day outlier amount.

70 Cost outlier - Adjustment to compensate for additional costs.
Note: Changed as of 6/01

71 Primary Payer amount.
Note: Deleted as of 6/00. Use code 23.

72 Coinsurance day. (Handled in QTY, QTY01=CD)
Note: Inactive for 003040

73 Administrative days.
Note: Inactive for 003050

74 Indirect Medical Education Adjustment.

75 Direct Medical Education Adjustment.

76 Disproportionate Share Adjustment.

77 Covered days. (Handled in QTY, QTY01=CA)
Note: Inactive for 003040

78 Non-Covered days/Room charge adjustment.

79 Cost Report days. (Handled in MIA15)
Note: Inactive for 003050

80 Outlier days. (Handled in QTY, QTY01=OU)
Note: Inactive for 003050

81 Discharges.
Note: Inactive for 003040

82 PIP days.
Note: Inactive for 003040

83 Total visits.
Note: Inactive for 003040

84 Capital Adjustment. (Handled in MIA)
Note: Inactive for 003050

85 Interest amount.

86 Statutory Adjustment.
Note: Inactive for 004010, since 6/98. Duplicative of code 45.

87 Transfer amount.

88 Adjustment amount represents collection against receivable created in prior overpayment.
Note: Inactive for 004050.

89 Professional fees removed from charges.

90 Ingredient cost adjustment.

91 Dispensing fee adjustment.

92 Claim Paid in full.
Note: Inactive for 003040

93 No Claim level Adjustments.
Note: Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.

94 Processed in Excess of charges.

95 Benefits adjusted. Plan procedures not followed.
Note: Changed as of 6/00

96 Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
Note: Changed as of 6/06

97 Payment is included in the allowance for another service/procedure.
Note: Changed as of 2/99

98 The hospital must file the Medicare claim for this inpatient non-physician service.
Note: Inactive for 003040

99 Medicare Secondary Payer Adjustment Amount.
Note: Inactive for 003040

100 Payment made to patient/insured/responsible party.

101 Predetermination: anticipated payment upon completion of services or claim adjudication.
Note: Changed as of 2/99

102 Major Medical Adjustment.

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

	Note: Changed as of 6/01
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this clai *Note: Changed as of 6/03*
108	Payment adjusted because rent/purchase guidelines were not met. *Note: Changed as of 6/02*
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	Payment adjusted as not furnished directly to the patient and/or not documented. *Note: Changed as of 2/01*
113	Payment denied because service/procedure was provided outside the United States or as a result of war. *Note: Changed as of 2/01; Inactive for version 004060. Use Codes 157, 158 or 159.*
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled. *Note: Changed as of 2/01*
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements. *Note: Changed as of 2/01*
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care. *Note: Changed as of 2/01*
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period or occurrence has been reached. *Note: Changed as of 2/04*
120	Patient is covered by a managed care plan. *Note: Inactive for 004030, since 6/99. Use code 24.*
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment. *Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.*
124	Payer refund amount - not our patient. *Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.*
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be prov (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) *Note: Changed as of 2/02 and 6/06*
126	Deductible -- Major Medical *Note: New as of 2/97*
127	Coinsurance -- Major Medical *Note: New as of 2/97*
128	Newborn's services are covered in the mother's Allowance. *Note: New as of 2/97*
129	Payment denied - Prior processing information appears incorrect. *Note: Changed as of 2/01*
130	Claim submission fee. *Note: Changed as of 6/01*
131	Claim specific negotiated discount. *Note: New as of 2/97*
132	Prearranged demonstration project adjustment. *Note: New as of 2/97*
133	The disposition of this claim/service is pending further review. *Note: Changed as of 10/99*
134	Technical fees removed from charges. *Note: New as of 10/98*
135	Claim denied. Interim bills cannot be processed.

	Note: New as of 10/98
136	Claim Adjusted. Plan procedures of a prior payer were not followed. *Note: Changed as of 6/00*
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. *Note: New as of 2/99*
138	Claim/service denied. Appeal procedures not followed or time limits not met. *Note: New as of 6/99*
139	Contracted funding agreement - Subscriber is employed by the provider of services. *Note: New as of 6/99*
140	Patient/Insured health identification number and name do not match. *Note: New as of 6/99*
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage. *Note: Changed as of 6/00*
142	Claim adjusted by the monthly Medicaid patient liability amount. *Note: New as of 6/00*
143	Portion of payment deferred. *Note: New as of 2/01*
144	Incentive adjustment, e.g. preferred product/service. *Note: New as of 6/01*
145	Premium payment withholding *Note: New as of 6/02*
146	Payment denied because the diagnosis was invalid for the date(s) of service reported. *Note: New as of 6/02*
147	Provider contracted/negotiated rate expired or not on file. *Note: New as of 6/02*
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete. *Note: New as of 6/02*
149	Lifetime benefit maximum has been reached for this service/benefit category. *Note: New as of 10/02*
150	Payment adjusted because the payer deems the information submitted does not support this level of service. *Note: New as of 10/02*
151	Payment adjusted because the payer deems the information submitted does not support this many services. *Note: New as of 10/02*
152	Payment adjusted because the payer deems the information submitted does not support this length of service. *Note: New as of 10/02*
153	Payment adjusted because the payer deems the information submitted does not support this dosage. *Note: New as of 10/02*
154	Payment adjusted because the payer deems the information submitted does not support this day's supply. *Note: New as of 10/02*
155	This claim is denied because the patient refused the service/procedure. *Note: New as of 6/03*
156	Flexible spending account payments *Note: New as of 9/03*
157	Payment denied/reduced because service/procedure was provided as a result of an act of war. *Note: New as of 9/03*
158	Payment denied/reduced because the service/procedure was provided outside of the United States. *Note: New as of 9/03*
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism. *Note: New as of 9/03*
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. *Note: New as of 9/03*
161	Provider performance bonus *Note: New as of 2/04*
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. *Note: New as of 2/04*
163	Claim/Service adjusted because the attachment referenced on the claim was not received.

	Note: New as of 6/04
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion. *Note: New as of 6/04*
165	Payment denied /reduced for absence of, or exceeded referral *Note: New as of 10/04*
166	These services were submitted after this payers responsibility for processing claims under this plan ended. *Note: New as of 2/05*
167	This (these) diagnosis(es) is (are) not covered. *Note: New as of 6/05*
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available und dental plan *Note: New as of 6/05*
169	Payment adjusted because an alternate benefit has been provided *Note: New as of 6/05*
170	Payment is denied when performed/billed by this type of provider. *Note: New as of 6/05*
171	Payment is denied when performed/billed by this type of provider in this type of facility. *Note: New as of 6/05*
172	Payment is adjusted when performed/billed by a provider of this specialty *Note: New as of 6/05*
173	Payment adjusted because this service was not prescribed by a physician *Note: New as of 6/05*
174	Payment denied because this service was not prescribed prior to delivery *Note: New as of 6/05*
175	Payment denied because the prescription is incomplete *Note: New as of 6/05*
176	Payment denied because the prescription is not current *Note: New as of 6/05*
177	Payment denied because the patient has not met the required eligibility requirements *Note: New as of 6/05*
178	Payment adjusted because the patient has not met the required spend down requirements. *Note: New as of 6/05*
179	Payment adjusted because the patient has not met the required waiting requirements *Note: New as of 6/05*
180	Payment adjusted because the patient has not met the required residency requirements *Note: New as of 6/05*
181	Payment adjusted because this procedure code was invalid on the date of service *Note: New as of 6/05*
182	Payment adjusted because the procedure modifier was invalid on the date of service *Note: New as of 6/05. Modified on 8/8/2005*
183	The referring provider is not eligible to refer the service billed. *Note: New as of 6/05*
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. *Note: New as of 6/05*
185	The rendering provider is not eligible to perform the service billed. *Note: New as of 6/05*
186	Payment adjusted since the level of care changed *Note: New as of 6/05*
187	Health Savings account payments *Note: New as of 6/05*
188	This product/procedure is only covered when used according to FDA recommendations. *Note: New as of 6/05*
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure co this procedure/service *Note: New as of 6/05*
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. *Note: New as of 10/05*

191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation *Note: New as of 10/05*
192	Non standard adjustment code from paper remittance advice. *Note: New as of 10/05*
193	Original payment decision is being maintained. This claim was processed properly the first time. *Note: New as of 2/06*
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending *Note: New as of 2/06*
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service *Note: New as of 2/06*
196	Claim/service denied based on prior payer's coverage determination. *Note: New as of 6/06*
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment. *Note: Inactive for version 004060. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustmen*
A3	Medicare Secondary Payer liability met. *Note: Inactive for 004010, since 6/98.*
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B2	Covered visits. *Note: Inactive for 003040*
B3	Covered charges. *Note: Inactive for 003040*
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. *Note: Changed as of 2/01*
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facil a provider of this specialty. *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. *Note: Changed as of 10/98*
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.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not 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 t payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered. *Note: Changed as of 2/01*
B15	Payment adjusted because this procedure/service is not paid separately. *Note: Changed as of 2/01*
B16	Payment adjusted because `New Patient' qualifications were not met. *Note: Changed as of 2/01*
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the presc incomplete, or the prescription is not current. *Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.*
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service *Note: Changed as of 2/01, 6/05*
B19	Claim/service adjusted because of the finding of a Review Organization.

Note: Inactive for 003070

B20 Payment adjusted because procedure/service was partially or fully furnished by another provider.
Note: Changed as of 2/01

B21 The charges were reduced because the service/care was partially furnished by another physician.
Note: Inactive for 003040

B22 This payment is adjusted based on the diagnosis.
Note: Changed as of 2/01

B23 Payment denied because this provider has failed an aspect of a proficiency testing program.
Note: Changed as of 2/01

D1 Claim/service denied. Level of subluxation is missing or inadequate.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D2 Claim lacks the name, strength, or dosage of the drug furnished.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or sup
missing.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D4 Claim/service does not indicate the period of time for which this will be needed.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D5 Claim/service denied. Claim lacks individual lab codes included in the test.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D6 Claim/service denied. Claim did not include patient's medical record for the service.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D7 Claim/service denied. Claim lacks date of patient's most recent physician visit.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D8 Claim/service denied. Claim lacks indicator that `x-ray is available for review.'
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the typ
intraocular lens used.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D10 Claim/service denied. Completed physician financial relationship form not on file.
Note: Inactive for 003070, since 8/97. Use code 17.

D11 Claim lacks completed pacemaker registration form.
Note: Inactive for 003070, since 8/97. Use code 17.

D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were
for the test.
Note: Inactive for 003070, since 8/97. Use code 17.

D13 Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial intere
Note: Inactive for 003070, since 8/97. Use code 17.

D14 Claim lacks indication that plan of treatment is on file.
Note: Inactive for 003070, since 8/97. Use code 17.

D15 Claim lacks indication that service was supervised or evaluated by a physician.
Note: Inactive for 003070, since 8/97. Use code 17.

D16 Claim lacks prior payer payment information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [N4].

D17 Claim/Service has invalid non-covered days.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M32, M33].

D18 Claim/Service has missing diagnosis information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [MA63, MA65].

D19 Claim/Service lacks Physician/Operative or other supporting documentation
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66]

D20 Claim/Service missing service/product information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67

D21 This (these) diagnosis(es) is (are) missing or are invalid
Note: New as of 6/05

W1 Workers Compensation State Fee Schedule Adjustment
Note: New as of 2/00