Data Requirements - Adjustment/Denial Reason Codes

FIGURE 2.G-1 DENIAL CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
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.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
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	The authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
24	Charges are covered under a capitation agreement/managed care plan.
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.
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 requirements.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) 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
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform 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	Procedure/treatment is deemed experimental/investigational by the payer.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
89	Professional fees removed from charges.
96	Non-covered charge(s).
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
98	The hospital must file the Medicare claim form for this inpatient non-physician service.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
113	Payment 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	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
119	Benefit maximum for this time period has been reached.
128	Newborn's services are covered in the mother's Allowance.
129	Prior processing information appears incorrect.
134	Technical fees removed from charges.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
135	Interim bills cannot be processed.
136	Failure to follow prior payer's coverage rules.
138	Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim spans eligible and ineligible periods of coverage.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Information from another provider was not provided or was insufficient/incomplete.
149	Benefit maximum for this time period or occurrence has been reached.
155	Patient refused the service/procedure.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is no current.
177	Patient has not met the required eligibility requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
188	This product/procedure is only covered when used according to FDA recommendations.
191	Not a work related injury/illness and thus not the liability of the Worker's Compensation carrier.
196	Claim/service denied based on prior payer's coverage determination.
199	Revenue code and procedure code do not match.
200	Expenses incurred during lapse in coverage.
201	Worker's Compensation (WC) case settled. Patient is responsible for amount of this claim/ service through WC "Medicare set aside arrangement" or other agreement.
202	Non-covered personal comfort or convenience services.
204	Payment adjusted for discontinued or reduced service.
206	National Provider Identifier - missing.
207	National Provider Identifier - Invalid format.
208	National Provider Identifier - Not matched.
213	Non-compliance with the physician self-referral prohibition legislation or payer policy.

HIPAA Adjustment Reason Codes Release 11/05/2007.

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
214	Worker's Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.
A1	Claim/service denied.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Ungroupable DRG.
B1	Non-covered visits.
B5	Coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B9	Patient is enrolled in a Hospice.
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	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
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.
B18	This procedure code and modifier were invalid on the date of service.
B20	Procedure/service was partially or fully furnished by another provider.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
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 of the amount you were charged for the test.
D13	Claim/service denied. Performed by the facility/supplier in which the ordering/referring physician has a financial interest.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
D16	Claim lacks prior payer payment information.
D17	Claim/Service has invalid non-covered days.
D18	Claim/Service has missing diagnosis information.
D19	Claim/Service lacks Physician/Operative or other supporting documentation.
D20	Claim/Service missing service/product information.
D21	This (these) diagnosis(es) is (are) missing or are invalid.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
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.
59	Processed based on multiple or concurrent procedure rules.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to prior claim.
65	Procedure code was incorrect. This payment reflects the correct code.
78	Non-Covered days/Room charge adjustment.
93	No Claim Level Adjustments.
95	Plan procedures not followed.
108	Rent/purchase guidelines were not met.
117	Transportation is only covered to the closest facility that can provide the necessary care.
120	Patient is covered by a managed care plan.
125	Submission/billing error(s).
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
150	Payer deems the information submitted does not support this level of services.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	Payer deems the information submitted does not support this length of service.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
163	Attachment referenced on the claim was not received.
164	Attachment referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
169	Alternate benefit has been provided.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Service was not prescribed by a physician.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements.
180	Patient has not met the required residency requirements.
186	Level of care change adjustment.
189	Not otherwise classified or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-2 DENIAL/ADJUSTMENT CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
203	Discontinued or reduced service.
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.
210	Payment adjusted because precertification/authorization not received in a timely fashion.
211	National Drug Codes (NDCs) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered.
215	Based on subrogation of a third party settlement.
216	Based on the findings of a review organization.
217	Based on the payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
218	Based on the entitlement to benefits.
219	Based on extent of injury.
221	Worker's Compensation claim is under investigation.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
A3	Medicare Secondary Payer liability met.
B4	Late filing penalty.
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.
B8	Alternative services were available, and should have been utilized.
B16	'New Patient' qualifications were not met.
B19	Claim/Service adjusted because of the finding of a Review Organization.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjusted based on the diagnosis.
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence.
HIPAA Adjustment Reason Codes Release 11/05/2007.	

FIGURE 2.G-3 ADJUSTMENT/REMARK CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
36	Balance does not exceed copayment amount.
37	Balance does not exceed deductible.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed fee schedule/maximum allowable or contracted/ legislated fee arrangement.
61	Penalty for failure to obtain second surgical opinion.
64	Denial reversed per Medical Review.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier amount - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.
74	Indirect Medical Education (IDME) Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
79	Cost Report days. (Handled in MIA15)
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total Visits.
84	Capital Adjustment. (Handled in MIA)
85	Patient Interest Adjustment.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
94	Processed in Excess of charges.

HIPAA Adjustment Reason Codes Release 11/05/2007.

FIGURE 2.G-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
99	Medicare Secondary Payer Adjustment Amount.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.
118	ESRD network support adjustment.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
145	Premium payment withholding.
156	Flexible spending account payment.
161	Provider performance bonus.
162	State-mandated requirement for property and casualty.
187	Health Savings account payments.
192	Non-standard adjustment code from paper remittance.
205	Pharmacy discount card processing fee.
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.
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837).
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.

HIPAA Adjustment Reason Codes Release 11/05/2007.

FIGURE 2.G-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
A7	Presumptive Payment Adjustment
B2	Covered visits.
B3	Covered charges.
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.
W1	Workers Compensation State Fee Schedule Adjustment
HIPAA Adjustment Reason Codes Release 11/05/2007.	

- END -