

## DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

**FIGURE 2-H-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	Payment adjusted because the submitted 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	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate.
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.

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**FIGURE 2-H-1 DENIAL CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
24	Payment for charges adjusted. 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.
<b>28</b>	<b>Coverage not in effect at the time the service was provided.</b>
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	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.
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.
<b>46</b>	<b>This (these) service(s) is (are) not covered.</b>
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
<b>48</b>	<b>This (these) procedure(s) is (are) not covered.</b>
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	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.

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**FIGURE 2-H-1 DENIAL CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
89	Professional fees removed from charges.
96	Non-covered charge(s).
97	Payment <b>adjusted because the benefit for this service</b> is included in the <b>payment/allowance for another service/procedure that has already been adjudicated.</b>
98	The hospital must file the Medicare claim for this inpatient non-physician service.
106	Patient payment option/election not in effect.
107	Claim/service <b>adjusted</b> because the related or qualifying claim/service was <b>not</b> identified on <b>this</b> claim.
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.
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	Payment adjusted as procedure postponed or canceled.
116	Payment denied. 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	Payment denied - Prior processing information appears incorrect.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim <b>adjusted based on failure to follow prior payer's coverage rules.</b>
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.

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**FIGURE 2-H-1 DENIAL CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
149	Benefit maximum for this time period or occurrence has been reached.
155	This claim is denied because the 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	Payment denied as 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	Payment denied because this service was not prescribed prior to delivery.
175	Payment denied because the prescription is incomplete.
176	Payment denied because the prescription is not current.
177	Payment denied because the patient has not met the required eligibility requirements.
181	Payment adjusted because this procedure code was invalid on the date of service.
182	Payment adjusted because the 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	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' 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.

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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
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	Payment adjusted due to non-covered personal comfort or convenience services.
204	Payment adjusted for discontinued or reduced service.
A1	Claim/service denied.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B5	Payment adjusted because 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	Services not covered because the 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	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because 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	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B23	Payment 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.
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**FIGURE 2-H-1 DENIAL CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
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.
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.
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FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
23	Payment adjusted because charges have been paid by another payer.
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	Charges are adjusted based on multiple or concurrent procedure rules.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to a 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	Benefits adjusted. Plan procedures not followed.
108	Payment reduced because rent/purchase guidelines were not met.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
120	Patient is covered by a managed care plan.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using remittance advice remarks codes whenever appropriate.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support his length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
157	Payment denied/reduced because the service/procedure was provided as a result of war.
158	Payment denied/reduced because the service was provided outside of the United States.
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.

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**FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
160	Payment denied/reduced because injury/illness was a result of an activity that is a benefit exclusion.
163	Claim/Service adjusted because the attachment referenced on the claim was not received.
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
165	Payment denied/reduced for absence of, or exceeded referral.
169	Payment adjusted because an alternate benefit has been provided.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Payment adjusted because this service was not prescribed by a physician.
178	Payment adjusted because the patient has not met the required spend down requirements.
179	Payment adjusted because the patient has not met the required waiting requirements.
180	Payment adjusted because the patient has not met the required residency requirements.
186	Payment adjusted since the level of care changed.
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.
193	Original payment decision is being maintained. This claim was processed properly the first time.
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon, or the attending physician.
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service.
197	Payment adjusted for absence of precertification/authorization.
198	Payment adjusted for exceeding precertification/authorization.
203	This service/equipment/drug is not covered under patient's current benefit.
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	Claim/service not covered/reduced because alternative services were available, and should have been utilized.

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**FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES (CONTINUED)**

<b>ADJUST/DENIAL REASON CODE</b>	<b>DESCRIPTION</b>
B16	Payment adjusted because "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.

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**FIGURE 2-H-3 ADJUSTMENT/REMARK CODES**

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Co-payment amount
36	Balance does not exceed co-payment 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 <b>fee schedule/maximum allowable</b> or contracted/ legislated fee arrangement.
61	Charges adjusted as 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 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	Interest amount.
86	Statutory Adjustment.
87	Transfer amount.

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**FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
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.
99	Medicare Secondary Payer Adjustment Amount.
100	Payment made to patient/insured/responsible party.
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	Charges reduced for ESRD network support.
121	Indemnification adjustment.
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	Claim adjusted by the 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.

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**FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)**

ADJUST/DENIAL REASON CODE	DESCRIPTION
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 advice.
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
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
<b>HIPAA Adjustment Reason Codes Release 09/01/2003.</b>	