

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 | 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. |
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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|------------------------------|---|
| 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. |
| 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). |

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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|------------------------------|--|
| 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 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. |
| 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. |

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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|--|---|
| 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 not 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. |
| 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. |
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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|------------------------------|--|
| 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/modifier was invalid on the date of service or claim submission. |
| 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. |

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FIGURE 2-H-1 DENIAL CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|--|--|
| 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 | 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 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 | 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 service. |
| 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 his 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 a 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. |
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FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES (CONTINUED)

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|------------------------------|---|
| 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. |
| 193 | Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. |
| 194 | Anesthesia is 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 (NDC) 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 payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. |
| 218 | Based on 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. |

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

| ADJUST/DENIAL REASON CODE | DESCRIPTION |
|--|---|
| 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. |
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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 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 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. |
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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/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. |

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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. |
| 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. |
| 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 | Worker's Compensation State Fee Schedule Adjustment. |
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