



Code Definition

1	Deductible amount. Start: 01/01/1995
2	Coinsurance amount. Start: 01/01/1995
3	Co-payment amount. Start: 01/01/1995
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 01/01/1995
5	The procedure code/bill type is inconsistent with the place of service. Start: 01/01/1995
6	The procedure/revenue code is inconsistent with the patient's age. Start: 01/01/1995 Last Modified: 06/30/2002
7	The procedure/revenue code is inconsistent with the patient's gender. Start: 01/01/1995 Last Modified: 06/30/2002
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Start: 01/01/1995 Last Modified: 06/30/2002
9	The diagnosis is inconsistent with the patient's age. Start: 01/01/1995
10	The diagnosis is inconsistent with the patient's gender. Start: 01/01/1995 Last Modified: 02/29/2000
11	The diagnosis is inconsistent with the procedure. Start: 01/01/1995
12	The diagnosis is inconsistent with the provider type. Start: 01/01/1995
13	The date of death precedes the date of service. Start: 01/01/1995
14	The date of birth follows the date of service. Start: 01/01/1995
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 Last Modified: 09/30/2007
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 01/01/1995 Last Modified: 06/30/2006
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 01/01/1995 Last Modified: 09/21/2008 Stop: 07/01/2009
18	Duplicate claim/service. Start: 01/01/1995
19	This is a work-related injury/illness and thus the liability of the worker's compensation carrier. Start: 01/01/1995 Last Modified: 09/30/2007
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 Last Modified: 09/30/2007
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 Last Modified: 09/30/2007
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 Last Modified: 09/30/2007
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 Last Modified: 09/30/2007
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 Last Modified: 09/30/2007
25	Payment denied. Your stop loss deductible has not been met. Start: 01/01/1995 Stop: 04/01/2008
26	Expenses incurred prior to coverage. Start: 01/01/1995

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code	Definition
27	Expenses incurred after coverage terminated. Start: 01/01/1995
28	Coverage not in effect at the time the service was provided. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Redundant to codes 26 & 27.</i>
29	The time limit for filing has expired. Start: 01/01/1995
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. Start: 01/01/1995 Stop: 02/01/2006
31	Patient cannot be identified as our insured. Start: 01/01/1995 Last Modified: 09/30/2007
32	Our records indicate that this dependent is not an eligible dependent as defined. Start: 01/01/1995
33	Insured has no dependent coverage. Start: 01/01/1995 Last Modified: 09/30/2007
34	Insured has no coverage for newborns. Start: 01/01/1995 Last Modified: 09/30/2007
35	Lifetime benefit maximum has been reached. Start: 01/01/1995 Last Modified: 10/31/2002
36	Balance does not exceed co-payment amount. Start: 01/01/1995 Stop: 10/16/2003
37	Balance does not exceed deductible. Start: 01/01/1995 Stop: 10/16/2003
38	Services not provided or authorized by designated (network/primary care) providers. Start: 01/01/1995 Last Modified: 06/30/2003
39	Services denied at the time authorization/pre-certification was requested. Start: 01/01/1995
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
41	Discount agreed to in Preferred Provider contract. Start: 01/01/1995 Stop: 10/16/2003
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45) Start: 01/01/1995 Last Modified: 10/31/2006 Stop: 06/01/2007
43	Gramm-Rudman reduction. Start: 01/01/1995 Stop: 07/01/2006
44	Prompt-pay discount. Start: 01/01/1995
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability). Start: 01/01/1995 Last Modified: 10/31/2006
46	This (these) service(s) is (are) not covered. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 96.</i>
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. Start: 01/01/1995 Stop: 02/01/2006
48	This (these) procedure(s) is (are) not covered. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 96.</i>
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Start: 01/01/1995

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code	Definition
50	These are non-covered services because this is not deemed a “medical necessity” by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a “medical necessity” by the payer. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
51	These are non-covered services because this is a pre-existing condition. Start: 01/01/1995
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. Start: 01/01/1995 Stop: 02/01/2006
53	Services by an immediate relative or a member of the same household are not covered. Start: 01/01/1995
54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
56	Procedure/treatment has not been deemed “proven to be effective” by the payer. This change to be effective 04/01/2010: Procedure/treatment has not been deemed “proven to be effective” by the payer. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
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. Start: 01/01/1995 Stop: 6/30/2007 <i>Note: Split into codes 150, 151, 152, 153, and 154.</i>
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
59	Processed based on multiple or concurrent procedure rules. (For example: multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example: multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services. Start: 01/01/1995 Last Modified: 06/01/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 Last Modified: 09/30/2007
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Start: 01/01/1995 Last Modified: 10/31/2006 Stop: 04/01/2007
63	Correction to a prior claim. Start: 01/01/1995 Stop: 10/16/2003
64	Denial reversed per medical review. Start: 01/01/1995 Stop: 10/16/2003
65	Procedure code was incorrect. This payment reflects the correct code. Start: 01/01/1995 Stop: 10/16/2003
66	Blood deductible. Start: 01/01/1995
67	Lifetime reserve days. (Handled in QTY, QTY01=LA) Start: 01/01/1995 Stop: 10/16/2003
68	DRG weight. (Handled in CLP12) Start: 01/01/1995 Stop: 10/16/2003

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code	Definition
69	Day outlier amount. Start: 01/01/1995
70	Cost outlier - adjustment to compensate for additional costs. Start: 01/01/1995 Last Modified: 06/30/2001
71	Primary payer amount. Start: 01/01/1995 Stop: 06/30/2000 <i>Note: Use code 23.</i>
72	Coinsurance day. (Handled in QTY, QTY01=CD) Start: 01/01/1995 Stop: 10/16/2003
73	Administrative days. Start: 01/01/1995 Stop: 10/16/2003
74	Indirect medical education adjustment. Start: 01/01/1995
75	Direct medical education adjustment. Start: 01/01/1995
76	Disproportionate share adjustment. Start: 01/01/1995
77	Covered days. (Handled in QTY, QTY01=CA) Start: 01/01/1995 Stop: 10/16/2003
78	Non-covered days/room charge adjustment. Start: 01/01/1995
79	Cost report days. (Handled in MIA15) Start: 01/01/1995 Stop: 10/16/2003
80	Outlier days. (Handled in QTY, QTY01=OU) Start: 01/01/1995 Stop: 10/16/2003
81	Discharges. Start: 01/01/1995 Stop: 10/16/2003
82	PIP days. Start: 01/01/1995 Stop: 10/16/2003
83	Total visits. Start: 01/01/1995 Stop: 10/16/2003
84	Capital adjustment. (Handled in MIA) Start: 01/01/1995 Stop: 10/16/2003
85	Patient interest adjustment (Use only group code PR.) Start: 01/01/1995 Last Modified: 01/01/2008 <i>Note: Only use when the payment of interest is the responsibility of the patient.</i>
86	Statutory adjustment. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Duplicative of code 45.</i>
87	Transfer amount. Start: 01/01/1995
88	Adjustment amount represents collection against receivable created in prior overpayment. Start: 01/01/1995 Stop: 06/30/2007
89	Professional fees removed from charges. Start: 01/01/1995
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Start: 01/01/1995 Last Modified: 07/01/2009 <i>Note: To be used for pharmaceuticals only.</i>
91	Dispensing fee adjustment. Start: 01/01/1995
92	Claim paid in full. Start: 01/01/1995 Stop: 10/16/2003
93	No claim level adjustments. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: As of 004010, CAS at the claim level is optional.</i>
94	Processed in excess of charges. Start: 01/01/1995

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

95	Plan procedures not followed. Start: 01/01/1995 Last Modified: 09/30/2007
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 01/01/1995 Last Modified: 6/30/2006
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 Last Modified: 09/30/2007
98	The hospital must file the Medicare claim for this inpatient non-physician service. Start: 01/01/1995 Stop: 10/16/2003
99	Medicare secondary payer adjustment amount. Start: 01/01/1995 Stop: 10/16/2003
100	Payment made to patient/insured/responsible party/employer. Start: 01/01/1995 Last Modified: 01/27/2008
101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start: 01/01/1995 Last Modified: 02/28/1999
102	Major medical adjustment. Start: 01/01/1995
103	Provider promotional discount (e.g., senior citizen discount). Start: 01/01/1995 Last Modified: 06/30/2001
104	Managed care withholding. Start: 01/01/1995
105	Tax withholding. Start: 01/01/1995
106	Patient payment option/election not in effect. Start: 01/01/1995
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 Last Modified: 09/30/2007
108	Rent/purchase guidelines were not met. Start: 01/01/1995 Last Modified: 09/30/2007
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Start: 01/01/1995
110	Billing date predates service date. Start: 01/01/1995
111	Not covered unless the provider accepts assignment. Start: 01/01/1995
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 Last Modified: 09/30/2007
113	Payment denied because service/procedure was provided outside the United States or as a result of war. Start: 01/01/1995 Last Modified: 02/28/2001 Stop: 06/30/2007 <i>Note: Use codes 157, 158, or 159.</i>
114	Procedure/product not approved by the Food and Drug Administration. Start: 01/01/1995
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 Last Modified: 09/30/2007
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 Last Modified: 09/30/2007
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 Last Modified: 09/30/2007
118	ESRD network support adjustment. Start: 01/01/1995 Last Modified: 09/30/2007
119	Benefit maximum for this time period or occurrence has been reached. Start: 01/01/1995 Last Modified: 02/29/2004
120	Patient is covered by a managed care plan. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 24.</i>

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 Last Modified: 09/30/2007
122	Psychiatric reduction. Start: 01/01/1995
123	Payer refund due to overpayment. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Refer to implementation guide for proper handling of reversals.</i>
124	Payer refund amount - not our patient. Start: 01/01/1995 Last Modified: 06/30/1999 Stop: 06/30/2007 <i>Note: Refer to implementation guide for proper handling of reversals.</i>
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 01/01/1995 Last Modified: 09/30/2007
126	Deductible -- Major Medical Start: 02/28/1997 Last Modified: 09/30/2007 Stop: 04/01/2008 <i>Note: Use group code PR and code 1.</i>
127	Coinsurance -- Major Medical Start: 02/28/1997 Last Modified: 09/30/2007 Stop: 04/01/2008 <i>Note: Use group code PR and code 2.</i>
128	Newborn's services are covered in the mother's allowance. Start: 02/28/1997
129	Prior processing information appears incorrect. Start: 02/28/1997 Last Modified: 09/30/2007
130	Claim submission fee. Start: 02/28/1997 Last Modified: 06/30/2001
131	Claim specific negotiated discount. Start: 02/28/1997
132	Prearranged demonstration project adjustment. Start: 02/28/1997
133	The disposition of this claim/service is pending further review. Start: 02/28/1997 Last Modified: 10/31/1999
134	Technical fees removed from charges. Start: 10/31/1998
135	Interim bills cannot be processed. Start: 10/31/1998 Last Modified: 09/30/2007
136	Failure to follow prior payer's coverage rules. (Use group code OA.) Start: 10/31/1998 Last Modified: 09/30/2007
137	Regulatory surcharges, assessments, allowances, or health related taxes. Start: 02/28/1999 Last Modified: 09/30/2007
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 Last Modified: 09/30/2007
139	Contracted funding agreement - subscriber is employed by the provider of services. Start: 06/30/1999
140	Patient/insured health identification number and name do not match. Start: 06/30/1999
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 Last Modified: 09/30/2007
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 Last Modified: 09/30/2007
143	Portion of payment deferred. Start: 02/28/2001
144	Incentive adjustment, e.g. preferred product/service. Start: 06/30/2001
145	Premium payment withholding. Start: 06/30/2002 Last Modified: 09/30/2007 Stop: 04/01/2008 <i>Note: Use group code CO and code 45.</i>

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code	Definition
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 Last Modified: 09/30/2007
147	Provider contracted/negotiated rate expired or not on file. Start: 06/30/2002
148	Information from another provider was not provided or was insufficient/incomplete. This change to be effective 7/1/2009: Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 06/30/2002 Last Modified: 09/21/2008
149	Lifetime benefit maximum has been reached for this service/benefit category. Start: 10/31/2002
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 Last Modified: 09/30/2007
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/2002 Last Modified: 01/27/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 Last Modified: 09/30/2007
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 Last Modified: 09/30/2007
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 Last Modified: 09/30/2007
155	Patient refused the service/procedure. Start: 06/30/2003 Last Modified: 09/30/2007
156	Flexible spending account payments. Start: 09/30/2003 Last Modified: 01/25/2009 Stop: 10/01/2009 <i>Note: Use code 187.</i>
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 Last Modified: 09/30/2007
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 Last Modified: 09/30/2007
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 Last Modified: 09/30/2007
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 Last Modified: 09/30/2007
161	Provider performance bonus. Start: 02/29/2004
162	State-mandated requirement for property and casualty; see Claim Payment Remarks Code for specific explanation. Start: 02/29/2004
163	Attachment referenced on the claim was not received. Start: 06/30/2004 Last Modified: 09/30/2007
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 Last Modified: 09/30/2007
165	Referral absent or exceeded. Start: 10/31/2004 Last Modified: 09/30/2007
166	These services were submitted after this payer's responsibility for processing claims under this plan ended. Start: 02/28/2005
167	This (these) diagnosis(es) is (are) not covered. Start: 06/30/2005
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 Last Modified: 09/30/2007
169	Alternate benefit has been provided. Start: 06/30/2005 Last Modified: 09/30/2007
170	Payment is denied when performed/billed by this type of provider. Start: 06/30/2005

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code	Definition
171	Payment is denied when performed/billed by this type of provider in this type of facility. Start: 06/30/2005
172	Payment is adjusted when performed/billed by a provider of this specialty. Start: 06/30/2005
173	Service was not prescribed by a physician. Start: 06/30/2005 Last Modified: 09/30/2007
174	Service was not prescribed prior to delivery. Start: 06/30/2005 Last Modified: 09/30/2007
175	Prescription is incomplete. Start: 06/30/2005 Last Modified: 09/30/2007
176	Prescription is not current. Start: 06/30/2005 Last Modified: 09/30/2007
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 Last Modified: 09/30/2007
178	Patient has not met the required spend-down requirements. Start: 06/30/2005 Last Modified: 09/30/2007
179	Patient has not met the required waiting requirements. Start: 06/30/2005 Last Modified: 09/30/2007
180	Patient has not met the required residency requirements. Start: 06/30/2005 Last Modified: 09/30/2007
181	Procedure code was invalid on the date of service. Start: 06/30/2005 Last Modified: 09/30/2007
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 Last Modified: 09/30/2007
183	The referring provider is not eligible to refer the service billed. Start: 6/30/2005
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Start: 06/30/2005
185	The rendering provider is not eligible to perform the service billed. Start: 06/30/2005
186	Level of care change adjustment. Start: 06/30/2005 Last Modified: 09/30/2007
187	Health savings account payments. This change to be effective 10/1/2009: Consumer spending account payments (includes but is not limited to flexible spending account, health savings account, health reimbursement account, etc.) Start: 06/30/2005 Last Modified: 01/25/2009
188	This product/procedure is only covered when used according to FDA recommendations. Start: 06/30/2005
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service. Start: 06/30/2005
190	Payment is included in the allowance for a skilled nursing facility (SNF) qualified stay. Start: 10/31/2005
191	Not a work related injury/illness and thus not the liability of the worker's compensation carrier. Start: 10/31/2005 Last Modified: 09/30/2007
192	Non-standard adjustment code from paper remittance. Start: 10/31/2005 Last Modified: 09/30/2007 <i>Note: This code is to be used by providers/payers providing coordination of benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claim Adjustment Reason Code, specifically Deductible, Coinsurance, and Copayment.</i>
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Start: 02/28/2006 Last Modified: 01/27/2008
194	Anesthesia performed by the operating physician, the assistant surgeon, or the attending physician. Start: 02/28/2006 Last Modified: 09/30/2007
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 Last Modified: 09/30/2007

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

- 196 Claim/service denied based on prior payer's coverage determination.
Start: 06/30/2006 | Stop: 02/01/2007
Note: Use code 136.
- 197 Precertification/authorization/notification absent.
Start: 10/31/2006 | Last Modified: 09/30/2007
- 198 Precertification/authorization exceeded.
Start: 10/31/2006 | Last Modified: 09/30/2007
- 199 Revenue code and procedure code do not match.
Start: 10/31/2006
- 200 Expenses incurred during lapse in coverage.
Start: 10/31/2006
- 201 Workers compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR.)
Start: 10/31/2006
- 202 Noncovered personal comfort or convenience services.
Start: 02/28/2007 | Last Modified: 09/30/2007
- 203 Discontinued or reduced service.
Start: 02/28/2007 | Last Modified: 09/30/2007
- 204 This service/equipment/drug is not covered under the patient's current benefit plan.
Start: 02/28/2007
- 205 Pharmacy discount card processing fee.
Start: 07/09/2007
- 206 National provider identifier - missing.
Start: 07/09/2007 | Last Modified: 09/30/2007
- 207 National provider identifier - invalid format.
Start: 07/09/2007 | Last Modified: 06/01/2008
- 208 National provider identifier - not matched.
Start: 07/09/2007 | Last Modified: 09/30/2007
- 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. (Use group code OA.)
Start: 07/09/2007
- 210 Payment adjusted because pre-certification/authorization not received in a timely fashion.
Start: 07/09/2007
- 211 National Drug Codes (NDC) not eligible for rebate; are not covered.
Start: 07/09/2007
- 212 Administrative surcharges are not covered.
Start: 11/05/2007
- 213 Non-compliance with the physician self-referral prohibition legislation or payer policy.
Start: 01/27/2008
- 214 Worker's compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
Start: 01/27/2008
Note: To be used for worker's compensation only.
- 215 Based on subrogation of a third party settlement.
Start: 01/27/2008
- 216 Based on the findings of a review organization.
Start: 01/27/2008
- 217 Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
Start: 01/27/2008
Note: To be used for worker's compensation only.
- 218 Based on entitlement to benefits.
Start: 01/27/2008
Note: To be used for worker's compensation only.
- 219 Based on extent of injury.
Start: 01/27/2008
Note: To be used for worker's compensation only.

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

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. Start: 01/27/2008 <i>Note: To be used for worker's compensation only.</i>
221	Worker's compensation claim is under investigation. Start: 01/27/2008 <i>Note: To be used for worker's compensation only. Claim pending final resolution.</i>
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start: 06/01/2008
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. Start: 06/01/2008
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start: 06/01/2008
225	Penalty or interest payment by payer. (Only used for plan to plan encounter reporting within the 837.) Start: 06/01/2008
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 09/21/2008
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 09/21/2008
228	Denied for failure of this provider, another provider, or the subscriber to supply requested information to a previous payer for their adjudication. Start: 09/21/2008
229	Partial charge amount not considered by Medicare due to the initial claim type of bill being 12X. Start: 01/25/2009 <i>Note: This code can only be used in the 837 transaction to convey coordination of benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use group code PR.</i>
230	No available or correlating CPT/HCPCS code to describe this service. Start: 01/25/2009 <i>Note: Used only by Property and Casualty.</i>
231	Mutually exclusive procedures cannot be done in the same day/setting. Start: 07/01/2009 <i>Note: Refer to the 835 Healthcare Policy Identification segment, if present.</i>
A0	Patient refund amount. Start: 01/01/1995
A1	Claim/service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Start: 01/01/1995 Last Modified: 10/31/2006
A2	Contractual adjustment. Start: 01/01/1995 Last Modified: 02/28/2007 Stop: 01/01/2008 <i>Note: Use code 45 with group code 'CO' or use another appropriate specific adjustment code.</i>
A3	Medicare secondary payer liability met. Start: 01/01/1995 Stop: 10/16/2003
A4	Medicare claim PPS capital day outlier amount. Start: 01/01/1995 Last Modified: 09/30/2007 Stop: 04/01/2008
A5	Medicare claim PPS capital cost outlier amount. Start: 01/01/1995

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

A6	Prior hospitalization or 30-day transfer requirement not met. Start: 01/01/1995
A7	Presumptive payment adjustment. Start: 01/01/1995
A8	Ungroupable DRG. Start: 01/01/1995 Last Modified: 09/30/2007
B1	Non-covered visits. Start: 01/01/1995
B2	Covered visits. Start: 01/01/1995 Stop: 10/16/2003
B3	Covered charges. Start: 01/01/1995 Stop: 10/16/2003
B4	Late filing penalty. Start: 01/01/1995
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 Last Modified: 09/30/2007
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. Start: 01/01/1995 Stop: 02/01/2006
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 01/01/1995 Last Modified: 10/31/1998
B8	Alternative services were available and should have been utilized. Start: 01/01/1995 Last Modified: 09/30/2007
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 Last Modified: 09/30/2007
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. Start: 01/01/1995
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. Start: 01/01/1995
B12	Services not documented in patient's medical records. Start: 01/01/1995
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 01/01/1995
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 Last Modified: 09/30/2007
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 Last Modified: 09/30/2007
B16	"New patient" qualifications were not met. Start: 01/01/1995 Last Modified: 09/30/2007
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. Start: 01/01/1995 Stop: 02/01/2006
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 Last Modified: 09/21/2008 Stop: 03/01/2009
B19	Claim/service adjusted because of the finding of a review organization. Start: 01/01/1995 Stop: 10/16/2003
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 Last Modified: 09/30/2007
B21	The charges were reduced because the service/care was partially furnished by another physician. Start: 01/01/1995 Stop: 10/16/2003
B22	This payment is adjusted based on the diagnosis. Start: 01/01/1995 Last Modified: 02/28/2001

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 Last Modified: 09/30/2007
D1	Claim/service denied. Level of subluxation is missing or inadequate. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D2	Claim lacks the name, strength, or dosage of the drug furnished. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D4	Claim/service does not indicate the period of time for which this will be needed. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D5	Claim/service denied. Claim lacks individual lab codes included in the test. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D6	Claim/service denied. Claim did not include patient's medical record for the service. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D8	Claim/service denied. Claim lacks indicator that "x-ray is available for review." Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
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. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 16 and remark codes if necessary.</i>
D10	Claim/service denied. Completed physician financial relationship form not on file. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D11	Claim lacks completed pacemaker registration form. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D14	Claim lacks indication that plan of treatment is on file. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D15	Claim lacks indication that service was supervised or evaluated by a physician. Start: 01/01/1995 Stop: 10/16/2003 <i>Note: Use code 17.</i>
D16	Claim lacks prior payer payment information. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 16 with appropriate claim payment remark code [N4].</i>

**American National Standards Institute (ANSI)
Claim Adjustment Reason Codes**

Code Definition

D17	Claim/service has invalid non-covered days. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 16 with appropriate claim payment remark code.</i>
D18	Claim/service has missing diagnosis information. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 16 with appropriate claim payment remark code.</i>
D19	Claim/service lacks physician/operative or other supporting documentation. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 16 with appropriate claim payment remark code.</i>
D20	Claim/service missing service/product information. Start: 01/01/1995 Stop: 06/30/2007 <i>Note: Use code 16 with appropriate claim payment remark code.</i>
D21	This (these) diagnosis(es) is (are) missing or invalid. Start: 01/01/1995 Stop: 06/30/2007
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code. Start: 01/27/2008 Stop: 01/01/2009 <i>Note: To be used for worker's compensation only.</i>
W1	Workers compensation state fee schedule adjustment. Start: 02/29/2000