CARC stands for Claim Adjustment Reason Code and provides the reason for a claim adjustment made by the payer. They help you understand why the claim amount differs from the billed amount. If no adjustment has been made, the claim will not have a CARC. There are several hundred CARCs and what they represent is standard across the industry.

CARC descriptions are often available on electronic remittance advice (ERA) and explanation of benefits (EOB) displays. CARCs can also be used to identify which ERAs need to be posted manually. This can bring certain claims to your attention and help you review these adjusted claims.

CARCs have group codes represented by two alpha characters. These include:

- **CO**: contractual obligation
- **PR**: patient responsibility
- **OA**: other adjustment
- **PI**: patient initiated reduction
- **CR**: corrections and/or reversal

What's a RARC?

RARC stands for Remittance Advice Remark Code and was first created as a proprietary list by Medicare, but it was later included in the HIPAA rules and has since become an industry standard. RARCs are now used by most insurance providers.

RARCs provide supplemental information regarding a rejected or adjusted claim. For example, if the CARC for a denied claim indicates that additional information is required, then the RARC will pinpoint exactly what information needs to be provided so the claim can be reconsidered.

RARCs can also provide miscellaneous information like appeal rights concerning the claim. Based on their utility, RARCs are of two types:

- **Supplemental**: Most RARCs are supplemental or RARCs without further distinction. These codes give additional information regarding why a claim was adjusted or denied.
- **Informational**: These are less common and usually start with alerts (usually mentioned in bold and red-lettered font). They provide information regarding remittance processing and not a specific adjusted claim or CARC.

What's the difference between CARCs and RARCs?

All adjusted claims are likely to have a CARC, but they may not always have a RARC. This is because CARCs convey the primary reason for a claim adjustment, whereas RARCs provide supplemental or additional information regarding the adjusted claim.

Top nine CARCs

Here's a list of the nine most popular CARCs from the Medicare JL page of Novitas Solutions:

CO-18

Healthcare insurers use this code to indicate a duplicate submission of an already processed claim. Ensuring each claim is unique avoids unnecessary delays in payment processing.

CO-22

This denial code is applicable when two or more insurance providers work together to provide compensation in such a way that avoids duplicate payments. This code is used when the cost of care may be covered by a secondary or alternate payer and not the one that has been billed.

CO-26

This denial code states, "Expenses incurred prior to coverage." It is applied when a claim is submitted for services rendered before the patient's health insurance coverage was active. Verifying insurance coverage dates before scheduling avoids denials.

CO-50

This denial code indicates services are not covered because the payer deems them medically unnecessary. This code identifies when insurance coverage criteria does not mesh with treatment provided.

CO-96

Payers use this code to indicate, non-covered charge(s). This code is a key alert for both healthcare providers and patients, highlighting the need to understand the specifics of insurance coverage and to confirm eligibility for certain services or items to avoid claim denials related to coverage limitations.

CO-97

This code signifies that the service was bundled in a payment/allowance for another service/procedure that has already been adjudicated. Essentially, this code indicates that the payment for a particular service or procedure is bundled into the payment of another service or procedure previously settled.

CO-109

This code applies when the claim is not covered by this payer/contractor. You must send the claim to the correct payer/contractor. This code is used to inform the healthcare provider or billing party that the submitted claim was directed to the wrong insurance company or payer, indicating the need to resubmit the claim to the appropriate entity for processing and reimbursement.

CO-170

Payers use this code to signify that they denied because the services were rendered or billed by a provider type that is not authorized under the patient's current insurance plan.

B-15

This code indicates that the claim has been denied because it lacks a prerequisite service or procedure that must be performed and covered as a condition for the billed service's coverage.

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. Usage: Refer to the 835 Healthcare Policy Ident Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 03/01/2020*
5	**The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcar Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
6	**The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Pol Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
7	**The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
8	**The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 H Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
9	**The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identificatio (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
10	**The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identifica Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
11	**The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification S (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
12	**The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identificatio (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

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*
16	**Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of ei NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Hea Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
18	**Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation re requires CO)** *Start: 01/01/1995 | Last Modified: 06/02/2013*
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. (Use only with Group C** *Start: 01/01/1995 | Last Modified: 09/30/2012*
24	**Charges are covered under a capitation agreement/managed care plan.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
26	**Expenses incurred prior to coverage.** *Start: 01/01/1995*
27	**Expenses incurred after coverage terminated.** *Start: 01/01/1995*
29	**The time limit for filing has expired.** *Start: 01/01/1995*

31	**Patient cannot be identified as our insured.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
32	**Our records indicate the patient is not an eligible dependent.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
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*
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. Usage: Refer to the 835 Healthcare Policy Id Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
44	**Prompt-pay discount.** *Start: 01/01/1995*
45	**Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This a amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustme (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Codes PR or CO depending upon liability)** *Start: 01/01/1995 | Last Modified: 07/01/2017*
49	**This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segm 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
50	**These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refe Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
51	**These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

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. Usage: Refer to the 835 Healthcare Policy Ident Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
55	**Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 H Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
56	**Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 H Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
58	**Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if** *Start: 01/01/1995 | Last Modified: 07/01/2017*
59	**Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic in concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Servic Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
60	**Charges for outpatient services are not covered when performed within a period of time prior to or after in services.** *Start: 01/01/1995 | Last Modified: 06/01/2008*
61	**Adjusted for failure to obtain second surgical opinion** *Start: 01/01/1995 | Last Modified: 03/01/2017* *Notes: The description effective date was inadvertently published as 3/1/2016 on 7/1/2016. That has been co 1/1/2017.*
66	**Blood Deductible.** *Start: 01/01/1995*
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*
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*
78	**Non-Covered days/Room charge adjustment.** *Start: 01/01/1995*
85	**Patient Interest Adjustment (Use Only Group code PR)** *Start: 01/01/1995 | Last Modified: 07/09/2007* *Notes: Only use when the payment of interest is the responsibility of the patient.*
89	**Professional fees removed from charges.** *Start: 01/01/1995*
90	**Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
91	**Dispensing fee adjustment.** *Start: 01/01/1995*
94	**Processed in Excess of charges.** *Start: 01/01/1995*
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 NCPD Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
97	**The benefit for this service is included in the payment/allowance for another service/procedure that has a been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Pay Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
100	**Payment made to patient/insured/responsible party.** *Start: 01/01/1995 | Last Modified: 05/01/2018*
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. Usage: Refer to the 835 Healthcare Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
108	**Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
109	**Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/** *Start: 01/01/1995 | Last Modified: 01/29/2012*
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*
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*
121	**Indemnification adjustment - compensation for outstanding member responsibility.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
122	**Psychiatric reduction.** *Start: 01/01/1995*
128	**Newborn's services are covered in the mother's Allowance.** *Start: 02/28/1997*
129	**Prior processing information appears incorrect. At least one Remark Code must be provided (may be comp either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 02/28/1997 | Last Modified: 01/30/2011*
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 service line is pending further review. (Use only with Group Code OA). Usage: Use o requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of Loop 2430 of the 837).** *Start: 07/01/2014 | Last Modified: 07/01/2017*
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 only with Group Code OA)** *Start: 10/31/1998 | Last Modified: 07/01/2013*

137	**Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.** *Start: 02/28/1999 | Last Modified: 09/30/2007*
139	**Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group C** *Start: 06/30/1999 | Last Modified: 05/01/2018*
140	**Patient/Insured health identification number and name do not match.** *Start: 06/30/1999*
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*
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. At least one Remark be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Co not an ALERT.)** *Start: 06/30/2002 | Last Modified: 09/20/2009*
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/freque services.** *Start: 10/31/2002 | Last Modified: 01/27/2008*
152	**Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 He Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 10/31/2002 | Last Modified: 07/01/2017*

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*
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*
163	**Attachment/other documentation referenced on the claim was not received.** *Start: 06/30/2004 | Last Modified: 06/02/2013*
164	**Attachment/other documentation referenced on the claim was not received in a timely fashion.** *Start: 06/30/2004 | Last Modified: 06/02/2013*
166	**These services were submitted after this payers responsibility for processing claims under this plan ended.** *Start: 02/28/2005*
167	**This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segr 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*
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. Usage: Refer to the 835 Healthcare Pol Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*

171	**Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to th Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*
172	**Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Health Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*
173	**Service/equipment was not prescribed by a physician.** *Start: 06/30/2005 | Last Modified: 07/01/2013*
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. Usage: Refer to the 835 Healthcare Policy Identific Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 03/01/2017*
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*

184	**The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 8 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*
185	**The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Poli Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 07/01/2017*
186	**Level of care change adjustment.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
187	**Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Sa 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 proc 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*
192	**Non standard adjustment code from paper remittance. Usage: This code is to be used by providers/payers Coordination of Benefits information to another payer in the 837 transaction only. This code is only used w non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifica Deductible, Coinsurance and Co-payment.** *Start: 10/31/2005 | Last Modified: 07/01/2017*
193	**Original payment decision is being maintained. Upon review, it was determined that this claim was proces 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*
197	**Precertification/authorization/notification/pre-treatment absent.** *Start: 10/31/2006 | Last Modified: 05/01/2018*

198	**Precertification/notification/authorization/pre-treatment exceeded.** *Start: 10/31/2006 | Last Modified: 05/01/2018*
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	**Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 10/31/2006 | Last Modified: 09/28/2014* *Notes: Not for use by Workers' Compensation payers; use code P3 instead.*
202	**Non-covered 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, th may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)** *Start: 07/09/2007 | Last Modified: 07/01/2013*
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*
215	**Based on subrogation of a third party settlement** *Start: 01/27/2008*
216	**Based on the findings of a review organization or the payer's findings.** *Start: 01/27/2008 | Last Modified: 03/01/2025*
219	**Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send and the provider refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifi the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider shoul the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).** *Start: 01/27/2008 | Last Modified: 07/01/2017*
222	**Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Info REF), if present.** *Start: 06/01/2008 | Last Modified: 07/01/2017*
223	**Adjustment code for mandated federal, state or local law/regulation that is not already covered by anothe 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 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 not provided timely or wa insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCP Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 09/21/2008 | Last Modified: 07/01/2013*
227	**Information requested from the patient/insured/responsible party was not provided or was insufficient/in At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code,**

	Remittance Advice Remark Code that is not an ALERT.) *Start: 09/21/2008 | Last Modified: 09/20/2009*
228	**Denied for failure of this provider, another provider or the subscriber to supply requested information to a 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. Usage: Th only be used in the 837 transaction to convey Coordination of Benefits information when the secondary pa avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code** *Start: 01/25/2009 | Last Modified: 07/01/2017*
231	**Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 07/01/2009 | Last Modified: 07/01/2017*
232	**Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount dif when the patient care crosses multiple institutions.** *Start: 11/01/2009 | Last Modified: 07/01/2017*
233	**Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.** *Start: 01/24/2010*
234	**This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of e NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 01/24/2010*
235	**Sales Tax** *Start: 06/06/2010*
236	**This procedure or procedure/modifier combination is not compatible with another procedure or procedur combination provided on the same day according to the National Correct Coding Initiative or workers com state regulations/ fee schedule requirements.** *Start: 01/30/2011 | Last Modified: 07/01/2013*
237	**Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either th Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 06/05/2011*
238	**Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use c Group Code PR)** *Start: 03/01/2012 | Last Modified: 07/01/2013*

239	**Claim spans eligible and ineligible periods of coverage. Rebill separate claims.** *Start: 03/01/2012 | Last Modified: 01/29/2012*
240	**The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Ide** **Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/03/2012 | Last Modified: 07/01/2017*
241	**Low Income Subsidy (LIS) Co-payment Amount** *Start: 06/03/2012*
242	**Services not provided by network/primary care providers.** *Start: 06/03/2012 | Last Modified: 06/02/2013* *Notes: This code replaces deactivated code 38*
243	**Services not authorized by network/primary care providers.** *Start: 06/03/2012 | Last Modified: 06/02/2013* *Notes: This code replaces deactivated code 38*
245	**Provider performance program withhold.** *Start: 09/30/2012*
246	**This non-payable code is for required reporting only.** *Start: 09/30/2012*
247	**Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.** *Start: 09/30/2012* *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA*
248	**Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim** *Start: 09/30/2012* *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA*
249	**This claim has been identified as a readmission. (Use only with Group Code CO)** *Start: 09/30/2012*
250	**The attachment/other documentation that was received was the incorrect attachment/document. The exp** **attachment/document is still missing. At least one Remark Code must be provided (may be comprised of e** **NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).** *Start: 09/30/2012 | Last Modified: 06/01/2014*
251	**The attachment/other documentation that was received was incomplete or deficient. The necessary inform** **still needed to process the claim. At least one Remark Code must be provided (may be comprised of either** **Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).** *Start: 09/30/2012 | Last Modified: 06/01/2014*

252	**An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Cod provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code an ALERT).** *Start: 09/30/2012 | Last Modified: 06/02/2013*
253	**Sequestration - reduction in federal payment** *Start: 06/02/2013 | Last Modified: 11/01/2013*
254	**Claim received by the dental plan, but benefits not available under this plan. Submit these services to the medical plan for further consideration.** *Start: 06/02/2013 | Last Modified: 11/01/2017* *Notes: Use CARC 290 if the claim was forwarded.*
256	**Service not payable per managed care contract.** *Start: 06/02/2013*
257	**The disposition of the claim/service is undetermined during the premium payment grace period, per Healt Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace perio to premium payment or lack of premium payment). (Use only with Group Code OA)** *Start: 11/01/2013 | Last Modified: 06/01/2014* *Notes: To be used after the first month of the grace period.*
258	**Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local autho cover the claim/service.** *Start: 11/01/2013*
259	**Additional payment for Dental/Vision service utilization.** *Start: 01/26/2014*
260	**Processed under Medicaid ACA Enhanced Fee Schedule** *Start: 01/26/2014*
261	**The procedure or service is inconsistent with the patient's history.** *Start: 06/01/2014*
262	**Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.** *Start: 11/01/2014 | Last Modified: 07/01/2017*
263	**Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.** *Start: 11/01/2014 | Last Modified: 07/01/2017*
264	**Adjustment for postage cost. Usage: To be used for pharmaceuticals only.** *Start: 11/01/2014 | Last Modified: 07/01/2017*

265	**Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.** *Start: 11/01/2014 | Last Modified: 07/01/2017*
266	**Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.** *Start: 11/01/2014 | Last Modified: 07/01/2017*
267	**Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of e NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 11/01/2014 | Last Modified: 04/01/2015*
268	**The Claim spans two calendar years. Please resubmit one claim per calendar year.** *Start: 11/01/2014*
269	**Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identificatio (loop 2110 Service Payment Information REF), if present.** *Start: 03/01/2015 | Last Modified: 07/01/2017*
270	**Claim received by the medical plan, but benefits not available under this plan. Submit these services to the dental plan for further consideration.** *Start: 07/01/2015 | Last Modified: 11/01/2017* *Notes: Use CARC 291 if the claim was forwarded.*
271	**Prior contractual reductions related to a current periodic payment as part of a contractual payment schedu deferred amounts have been previously reported. (Use only with Group Code OA)** *Start: 11/01/2015 | Last Modified: 03/01/2018*
272	**Coverage/program guidelines were not met.** *Start: 11/01/2015*
273	**Coverage/program guidelines were exceeded.** *Start: 11/01/2015*
274	**Fee/Service not payable per patient Care Coordination arrangement.** *Start: 11/01/2015*
275	**Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use or Group Code PR)** *Start: 11/01/2015*
276	**Services denied by the prior payer(s) are not covered by this payer.** *Start: 11/01/2015*
277	**The disposition of the claim/service is undetermined during the premium payment grace period, per Healt Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)**

	Start: 11/01/2015 *Notes: To be used during 31 day SHOP grace period.*
278	**Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refe 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 07/01/2016 | Last Modified: 07/01/2017*
279	**Services not provided by Preferred network providers. Usage: Use this code when there are member netw limitations. For example, using contracted providers not in the member's 'narrow' network.** *Start: 11/01/2016 | Last Modified: 07/01/2017*
280	**Claim received by the medical plan, but benefits not available under this plan. Submit these services to the Pharmacy plan for further consideration.** *Start: 03/01/2017 | Last Modified: 11/01/2017* *Notes: Use CARC 292 if the claim was forwarded.*
281	**Deductible waived per contractual agreement. Use only with Group Code CO.** *Start: 07/01/2017*
282	**The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 07/01/2017*
283	**Attending provider is not eligible to provide direction of care.** *Start: 11/01/2017*
284	**Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the l services.** *Start: 11/01/2017*
285	**Appeal procedures not followed** *Start: 11/01/2017*
286	**Appeal time limits not met** *Start: 11/01/2017*
287	**Referral exceeded** *Start: 11/01/2017*
288	**Referral absent** *Start: 11/01/2017*

289	**Services considered under the dental and medical plans, benefits not available.** *Start: 11/01/2017* *Notes: Also see CARCs 254, 270 and 280.*
290	**Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to patient's medical plan for further consideration.** *Start: 11/01/2017* *Notes: Use CARC 254 if the claim was not forwarded.*
291	**Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded t patient's dental plan for further consideration.** *Start: 11/01/2017* *Notes: Use CARC 270 if the claim was not forwarded.*
292	**Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded t patient's pharmacy plan for further consideration.** *Start: 11/01/2017* *Notes: Use CARC 280 if the claim was not forwarded.*
293	**Payment made to employer.** *Start: 05/01/2018*
294	**Payment made to attorney.** *Start: 11/01/2017*
295	**Pharmacy Direct/Indirect Remuneration (DIR)** *Start: 03/01/2018*
296	**Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the** *Start: 07/01/2018*
297	**Claim received by the medical plan, but benefits not available under this plan. Submit these services to the vision plan for further consideration.** *Start: 03/01/2019*
298	**Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded t patient's vision plan for further consideration.** *Start: 03/01/2019*
299	**The billing provider is not eligible to receive payment for the service billed.** *Start: 07/01/2019*

300	**Claim received by the Medical Plan, but benefits not available under this plan. Claim has been forwarded t patient's Behavioral Health Plan for further consideration.** *Start: 07/01/2019*
301	**Claim received by the Medical Plan, but benefits not available under this plan. Submit these services to the Behavioral Health Plan for further consideration.** *Start: 07/01/2019*
302	**Precertification/notification/authorization/pre-treatment time limit has expired.** *Start: 11/01/2020*
303	**Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered for Qua Medicare and Medicaid Beneficiaries. (Use only with Group Code CO)** *Start: 07/01/2021*
304	**Claim received by the medical plan, but benefits not available under this plan. Submit these services to the hearing plan for further consideration.** *Start: 03/01/2022*
305	**Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded t patient's hearing plan for further consideration.** *Start: 03/01/2022*
306	**Type of bill is inconsistent with the patient status. Usage: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.** *Start: 11/01/2023*
307	**Medicare Maximum Fair Price Standard Default Refund Amount Adjustment. At least one Remark Code mu provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code an ALERT.) Usage: To be used only for the Medicare Drug Price Negotiation Program.** *Start: 03/01/2025*
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 NCPDP Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a r specific Claim Adjustment Reason Code is not available.** *Start: 01/01/1995 | Last Modified: 11/16/2022*
A5	**Medicare Claim PPS Capital Cost Outlier Amount.** *Start: 01/01/1995*

A6	**Prior hospitalization or 30 day transfer requirement not met.** *Start: 01/01/1995*
A8	**Ungroupable DRG.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B1	**Non-covered visits.** *Start: 01/01/1995*
B4	**Late filing penalty.** *Start: 01/01/1995*
B7	**This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage:** **the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
B8	**Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Poli** **Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
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 benef** **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 co** **this payer/processor.** *Start: 01/01/1995*
B12	**Services not documented in patient's medical records.** *Start: 01/01/1995 | Last Modified: 03/01/2018*
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 qualifyi** **service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identifica** **Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

B16	**'New Patient' qualifications were not met.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B20	**Procedure/service was partially or fully furnished by another provider.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B22	**This payment is adjusted based on the diagnosis.** *Start: 01/01/1995 | Last Modified: 02/28/2001*
B23	**Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficienc** *Start: 01/01/1995 | Last Modified: 09/30/2007*
P1	**State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific exp To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 162*
P2	**Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If a is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Numb (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustme Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification S (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code 191*
P3	**Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'M set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Gr PR)** *Start: 11/01/2013* *Notes: This code replaces deactivated code 201*
P4	**Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/t Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 In Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictiona regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Comp only** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code 214*
P5	**Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arranger used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 217*

P6	**Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information RE 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provid refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To for Property and Casualty only.** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code 218*
P7	**The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 220*
P8	**Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provi refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifi the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider shou the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used Property and Casualty only.** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code 221*
P9	**No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty** *Start: 11/01/2013* *Notes: This code replaces deactivated code 230*
P10	**Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 244*
P11	**The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To b Property and Casualty only. (Use only with Group Code OA)** *Start: 11/01/2013* *Notes: This code replaces deactivated code 255*
P12	**Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 21 Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider sh to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the reg apply. To be used for Workers' Compensation only.** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code W1*
P13	**Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policie if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the prov**

	refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifi the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provid refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if t regulations apply. To be used for Workers' Compensation only. *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code W2*
P14	**The Benefit for this Service is included in the payment/allowance for another service/procedure that has b performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S Payment Information REF), if present. To be used for Property and Casualty only.** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code W3*
P15	**Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation** *Start: 11/01/2013* *Notes: This code replaces deactivated code W4*
P16	**Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To b Workers' Compensation only. (Use with Group Code CO or OA)** *Start: 11/01/2013* *Notes: This code replaces deactivated code W5*
P17	**Referral not authorized by attending physician per regulatory requirement. To be used for Property and Ca** *Start: 11/01/2013* *Notes: This code replaces deactivated code W6*
P18	**Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable serv used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W7*
P19	**Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be u Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W8*
P20	**Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Ca only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W9*
P21	**Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) E jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must s the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Inf REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must s the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment**

	information REF) if the regulations apply. To be used for Property and Casualty Auto only. *Start: 11/01/2013 | Last Modified: 03/01/2018* *Notes: This code replaces deactivated code Y1*
P22	**Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must s the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Inf REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must s the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.** *Start: 11/01/2013 | Last Modified: 03/01/2018* *Notes: This code replaces deactivated code Y2*
P23	**Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule a Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Cl Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segme 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto** *Start: 11/01/2013 | Last Modified: 07/01/2017* *Notes: This code replaces deactivated code Y3*
P24	**Payment adjusted based on Preferred Provider Organization (PPO). Usage: If adjustment is at the Claim Lev payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (L Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the prov refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if t regulations apply. To be used for Property and Casualty only. Use only with Group Code CO.** *Start: 11/01/2017*
P25	**Payment adjusted based on Medical Provider Network (MPN). Usage: If adjustment is at the Claim Level, t must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 21 Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider sh to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the reg apply. To be used for Property and Casualty only. (Use only with Group Code CO).** *Start: 11/01/2017*
P26	**Payment adjusted based on Voluntary Provider network (VPN). Usage: If adjustment is at the Claim Level, must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 21 Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider sh to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the reg apply. To be used for Property and Casualty only. (Use only with Group Code CO).** *Start: 11/01/2017*
P27	**Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policie adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance P Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regula applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 He**

	Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be u Property and Casualty Auto only. *Start: 11/01/2017*
P28	**Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment polic If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regula applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 He Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be u Property and Casualty Auto only.** *Start: 11/01/2017*
P29	**Liability Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the pay send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Ot Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should r 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulatio be used for Property and Casualty Auto only.** *Start: 11/01/2017*
P30	**Payment denied for exacerbation when supporting documentation was not complete. To be used for Prope Casualty only.** *Start: 11/01/2020*
P31	**Payment denied for exacerbation when treatment exceeds time allowed. To be used for Property and Casu** *Start: 11/01/2020*
P32	**Payment adjusted due to Apportionment.** *Start: 08/01/2022*

RARC codes (Remittance Advice Remark Codes) are standardized codes used in medical billing to provide additional details about claim adjustments. They complement **CARC codes** (Claim Adjustment Reason Codes) by offering more specific explanations for adjustments or denials. RARC codes are alphanumeric (e.g., N30: “Patient out-of-pocket exceeded”) and always appear alongside CARC codes, never independently. They serve as a universal language for claim adjustments and payment processing, helping to bridge communication gaps between payers and providers….

M1	**X-ray not taken within the past 12 months or near enough to the start of treatment.** *Start: 01/01/1997*
M2	**Not paid separately when the patient is an inpatient.** *Start: 01/01/1997*
M3	**Equipment is the same or similar to equipment already being used.** *Start: 01/01/1997*

M4	**Alert: This is the last monthly installment payment for this durable medical equipment.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
M5	**Monthly rental payments can continue until the earlier of the 15th month from the first rental month, o month when the equipment is no longer needed.** *Start: 01/01/1997*
M6	**Alert: You must furnish and service this item for any period of medical need for the remainder of the re useful lifetime of the equipment.** *Start: 01/01/1997 | Last Modified: 03/01/2009* *Notes: (Modified 4/1/07, 3/1/2009)*
M7	**No rental payments after the item is purchased, returned or after the total of issued rental payments eq purchase price.** *Start: 01/01/1997 | Last Modified: 11/01/2016* *Notes: (Modified 11/1/2016)*
M8	**We do not accept blood gas tests results when the test was conducted by a medical supplier or taken w patient is on oxygen.** *Start: 01/01/1997*
M9	**Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a p agreement.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
M10	**Equipment purchases are limited to the first or the tenth month of medical necessity.** *Start: 01/01/1997*
M11	**DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.** *Start: 01/01/1997*
M12	**Diagnostic tests performed by a physician must indicate whether purchased services are included on th** *Start: 01/01/1997*
M13	**Only one initial visit is covered per specialty per medical group.** *Start: 01/01/1997 | Last Modified: 06/30/2007* *Notes: (Modified 6/30/03)*
M14	**No separate payment for an injection administered during an office visit, and no payment for a full offic the patient only received an injection.** *Start: 01/01/1997*

M15	**Separately billed services/tests have been bundled as they are considered components of the same pro** **Separate payment is not allowed.** *Start: 01/01/1997*
M16	**Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Reactivated 4/1/04, Modified 11/18/05, 4/1/07)*
M17	**Alert: Payment approved as you did not know, and could not reasonably have been expected to know, t** **would not normally have been covered for this patient. In the future, you will be liable for charges for t** **service(s) under the same or similar conditions.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
M18	**Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is** **considered to be a patient's home.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
M19	**Missing oxygen certification/re-certification.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N234*
M20	**Missing/incomplete/invalid HCPCS.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M21	**Missing/incomplete/invalid place of residence for this service/item provided in a home.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M22	**Missing/incomplete/invalid number of miles traveled.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M23	**Missing invoice.** *Start: 01/01/1997 | Last Modified: 08/01/2005* *Notes: (Modified 8/1/05)*
M24	**Missing/incomplete/invalid number of doses per vial.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M25	**The information furnished does not substantiate the need for this level of service. If you believe the ser** **have been fully covered as billed, or if you did not know and could not reasonably have been expected**

	that we would not pay for this level of service, or if you notified the patient in writing in advance that w not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 1 the date of this notice. If you do not request an appeal, we will, upon application from the patient, reim him/her for the amount you have collected from him/her in excess of any deductible and coinsurance a We will recover the reimbursement from you as an overpayment. *Start: 01/01/1997 | Last Modified: 11/01/2010* *Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)*
M26	**The information furnished does not substantiate the need for this level of service. If you have collected amount from the patient for this level of service/any amount that exceeds the limiting charge for the le extensive service, the law requires you to refund that amount to the patient within 30 days of receiving notice.** **The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section spe physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil moneta and/or exclusion from the program. If you have any questions about this notice, please contact this offi** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)*
M27	**Alert: The patient has been relieved of liability of payment of these items and services under the limita liability provision of the law. The provider is ultimately liable for the patient's waived charges, including charges for coinsurance, since the items or services were not reasonable and necessary or constituted c care, and you knew or could reasonably have been expected to know, that they were not covered. You this determination. You may ask for an appeal regarding both the coverage determination and the issue whether you exercised due care. The appeal request must be filed within 120 days of the date you recei notice. You must make the request through this office.** *Start: 01/01/1997 | Last Modified: 08/01/2007* *Notes: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)*
M28	**This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise ava** *Start: 01/01/1997*
M29	**Missing operative note/report.** *Start: 01/01/1997 | Last Modified: 07/01/2008* *Notes: (Modified 2/28/03, 7/1/2008) Related to N233*
M30	**Missing pathology report.** *Start: 01/01/1997 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04, 2/28/03) Related to N236*
M31	**Missing radiology report.** *Start: 01/01/1997 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04, 2/28/03) Related to N240*
M32	**Alert: This is a conditional payment made pending a decision on this service by the patient's primary pa payment may be subject to refund upon your receipt of any additional payment for this service from an**

	payer. You must contact this office immediately upon receipt of an additional payment for this service. *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
M36	**This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given of changing the rental to a purchase.** *Start: 01/01/1997*
M37	**Not covered when the patient is under age 35.** *Start: 01/01/1997 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
M38	**Alert: The patient is liable for the charges for this service as they were informed in writing before the se furnished that we would not pay for it and the patient agreed to be responsible for the charges.** *Start: 01/01/1997 | Last Modified: 07/01/2015* *Notes: (Modified 7/1/15)*
M39	**Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you pr patient did not comply with program requirements.** *Start: 01/01/1997 | Last Modified: 07/01/2015* *Notes: (Modified 2/1/04, 4/1/07, 11/1/09, 11/1/12, 7/1/15) Related to N563*
M40	**Claim must be assigned and must be filed by the practitioner's employer.** *Start: 01/01/1997*
M41	**We do not pay for this as the patient has no legal obligation to pay for this.** *Start: 01/01/1997*
M42	**The medical necessity form must be personally signed by the attending physician.** *Start: 01/01/1997*
M44	**Missing/incomplete/invalid condition code.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M45	**Missing/incomplete/invalid occurrence code(s).** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N299*
M46	**Missing/incomplete/invalid occurrence span code(s).** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N300*
M47	**Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, l limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DC**

	Start: 01/01/1997 | Last Modified: 07/01/2015 *Notes: (Modified 2/28/03, 7/1/15)*
M49	**Missing/incomplete/invalid value code(s) or amount(s).** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M50	**Missing/incomplete/invalid revenue code(s).** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M51	**Missing/incomplete/invalid procedure code(s).** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N301*
M52	**Missing/incomplete/invalid 'from' date(s) of service.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M53	**Missing/incomplete/invalid days or units of service.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M54	**Missing/incomplete/invalid total charges.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M55	**We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral an drug.** *Start: 01/01/1997*
M56	**Missing/incomplete/invalid payer identifier.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M59	**Missing/incomplete/invalid 'to' date(s) of service.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M60	**Missing Certificate of Medical Necessity.** *Start: 01/01/1997 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04, 6/30/03) Related to N227*

M61	**We cannot pay for this as the approval period for the FDA clinical trial has expired.** *Start: 01/01/1997*
M62	**Missing/incomplete/invalid treatment authorization code.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M64	**Missing/incomplete/invalid other diagnosis.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M65	**One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indic** **Please submit a separate claim for each interpreting physician.** *Start: 01/01/1997*
M66	**Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code** **includes a professional component. Only the technical component is subject to price limitations. Please** **technical and professional components of this service as separate line items.** *Start: 01/01/1997*
M67	**Missing/incomplete/invalid other procedure code(s).** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N302*
M69	**Paid at the regular rate as you did not submit documentation to justify the modified procedure code.** *Start: 01/01/1997 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04)*
M70	**Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but pleas** **to submit the NDC on future claims for this item.** *Start: 01/01/1997 | Last Modified: 08/01/2007* *Notes: (Modified 4/1/2007, 8/1/07)*
M71	**Total payment reduced due to overlap of tests billed.** *Start: 01/01/1997*
M73	**The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Reb** **separate professional and technical components.** *Start: 01/01/1997 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04)*
M74	**This service does not qualify for a HPSA/Physician Scarcity bonus payment.** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04)*

M75	**Multiple automated multichannel tests performed on the same day combined for payment.** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/07)*
M76	**Missing/incomplete/invalid diagnosis or condition.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M77	**Missing/incomplete/invalid/inappropriate place of service.** *Start: 01/01/1997 | Last Modified: 03/14/2014* *Notes: (Modified 2/28/03, 3/1/2014, 3/14/2014)*
M79	**Missing/incomplete/invalid charge.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M80	**Not covered when performed during the same session/date as a previously processed service for the pa** *Start: 01/01/1997 | Last Modified: 10/31/2002* *Notes: (Modified 10/31/02)*
M81	**You are required to code to the highest level of specificity.** *Start: 01/01/1997 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04)*
M82	**Service is not covered when patient is under age 50.** *Start: 01/01/1997*
M83	**Service is not covered unless the patient is classified as at high risk.** *Start: 01/01/1997*
M84	**Medical code sets used must be the codes in effect at the time of service.** *Start: 01/01/1997 | Last Modified: 03/14/2014* *Notes: (Modified 2/1/04, 3/14/2014)*
M85	**Subjected to review of physician evaluation and management services.** *Start: 01/01/1997*
M86	**Service denied because payment already made for same/similar procedure within set time frame.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
M87	**Claim/service(s) subjected to CFO-CAP prepayment review.** *Start: 01/01/1997*

M89	**Not covered more than once under age 40.** *Start: 01/01/1997*
M90	**Not covered more than once in a 12 month period.** *Start: 01/01/1997*
M91	**Lab procedures with different CLIA certification numbers must be billed on separate claims.** *Start: 01/01/1997*
M93	**Information supplied supports a break in therapy. A new capped rental period began with delivery of th equipment.** *Start: 01/01/1997*
M94	**Information supplied does not support a break in therapy. A new capped rental period will not begin.** *Start: 01/01/1997*
M95	**Services subjected to Home Health Initiative medical review/cost report audit.** *Start: 01/01/1997*
M96	**The technical component of a service furnished to an inpatient may only be billed by that inpatient faci must contact the inpatient facility for technical component reimbursement. If not already billed, you sh for the professional component only.** *Start: 01/01/1997*
M97	**Not paid to practitioner when provided to patient in this place of service. Payment included in the reim issued the facility.** *Start: 01/01/1997*
M99	**Missing/incomplete/invalid Universal Product Number/Serial Number.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M100	**We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or w hours of administration of a covered chemotherapy drug.** *Start: 01/01/1997*
M102	**Service not performed on equipment approved by the FDA for this purpose.** *Start: 01/01/1997*
M103	**Information supplied supports a break in therapy. However, the medical information we have for this p not support the need for this item as billed. We have approved payment for this item at a reduced level new capped rental period will begin with the delivery of this equipment.** *Start: 01/01/1997*

M104	**Information supplied supports a break in therapy. A new capped rental period will begin with delivery o equipment. This is the maximum approved under the fee schedule for this item or service.** *Start: 01/01/1997*
M105	**Information supplied does not support a break in therapy. The medical information we have for this pat not support the need for this item as billed. We have approved payment for this item at a reduced level new capped rental period will not begin.** *Start: 01/01/1997*
M107	**Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.** *Start: 01/01/1997*
M109	**We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.** *Start: 01/01/1997*
M111	**We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken** *Start: 01/01/1997*
M112	**Reimbursement for this item is based on the single payment amount required under the DMEPOS Comp Bidding Program for the area where the patient resides.** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/07)*
M113	**Our records indicate that this patient began using this item/service prior to the current contract period DMEPOS Competitive Bidding Program.** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/07)*
M114	**This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bid Program or a Demonstration Project. For more information regarding these projects, contact your local** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 8/1/06, 11/5/07)*
M115	**This item is denied when provided to this patient by a non-contract or non-demonstration supplier.** *Start: 01/01/1997 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/2007)*
M116	**Processed under a demonstration project or program. Project or program is ending and additional servi not be paid under this project or program.** *Start: 01/01/1997 | Last Modified: 03/08/2011* *Notes: (Modified 2/1/04, 3/15/11)*

M117	**Not covered unless submitted via electronic claim.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
M119	**Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 2/28/03, 4/1/04)*
M121	**We pay for this service only when performed with a covered cryosurgical ablation.** *Start: 01/01/1997*
M122	**Missing/incomplete/invalid level of subluxation.** *Start: 01/01/1997 | Last Modified: 02/28/2006* *Notes: (Modified 2/28/03)*
M123	**Missing/incomplete/invalid name, strength, or dosage of the drug furnished.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M124	**Missing indication of whether the patient owns the equipment that requires the part or supply.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N230*
M125	**Missing/incomplete/invalid information on the period of time for which the service/supply/equipment needed.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M126	**Missing/incomplete/invalid individual lab codes included in the test.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M127	**Missing patient medical record for this service.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N237*
M129	**Missing/incomplete/invalid indicator of x-ray availability for review.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 2/28/03, 6/30/03)*
M130	**Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of int lens used.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N231*

M131	**Missing physician financial relationship form.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N239*
M132	**Missing pacemaker registration form.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N235*
M133	**Claim did not identify who performed the purchased diagnostic test or the amount you were charged fo** *Start: 01/01/1997*
M134	**Performed by a facility/supplier in which the provider has a financial interest.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
M135	**Missing/incomplete/invalid plan of treatment.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M136	**Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
M137	**Part B coinsurance under a demonstration project or pilot program.** *Start: 01/01/1997 | Last Modified: 11/01/2012* *Notes: (Modified 11/1/12)*
M138	**Patient identified as a demonstration participant but the patient was not enrolled in the demonstration time services were rendered. Coverage is limited to demonstration participants.** *Start: 01/01/1997*
M139	**Denied services exceed the coverage limit for the demonstration.** *Start: 01/01/1997*
M141	**Missing physician certified plan of care.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N238*
M142	**Missing American Diabetes Association Certificate of Recognition.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N226*

M143	**The provider must update license information with the payer.** *Start: 01/01/1997 | Last Modified: 12/01/2006* *Notes: (Modified 12/1/06)*
M144	**Pre-/post-operative care payment is included in the allowance for the surgery/procedure.** *Start: 01/01/1997*
MA01	**Alert: If you do not agree with what we approved for these services, you may appeal our decision. To m that we are fair to you, we require another individual that did not process your initial claim to conduct However, in order to be eligible for an appeal, you must write to us within 120 days of the date you rec notice, unless you have a good reason for being late.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)*
MA02	**Alert: If you do not agree with this determination, you have the right to appeal. You must file a written an appeal within 180 days of the date you receive this notice.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 10/31/02, 6/30/03, 8/1/05, 12/29/05, 8/1/06, 4/1/07)*
MA04	**Secondary payment cannot be considered without the identity of or payment information from the pri The information was either not reported or was illegible.** *Start: 01/01/1997*
MA07	**Alert: The claim information has also been forwarded to Medicaid for review.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA08	**Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap you do not participate in Medicare.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA09	**Alert: Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.** *Start: 01/01/1997 | Last Modified: 11/01/2015* *Notes: (Modified 11/1/2014, 11/1/2015)*
MA10	**Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to t** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA12	**You have not established that you have the right under the law to bill for services furnished by the pers furnished this (these) service(s).** *Start: 01/01/1997*

MA13	**Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (pati responsibility) group code.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA14	**Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside th plan are not covered. However, as you were not previously notified of this, we are paying this time. In t we will not pay you for non-plan services.** *Start: 01/01/1997 | Last Modified: 08/01/2007* *Notes: (Modified 4/1/07, 8/1/07)*
MA15	**Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the oth reported.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA16	**The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal B Program, P.O. Box 828, Lanham-Seabrook MD 20703.** *Start: 01/01/1997*
MA17	**We are the primary payer and have paid at the primary rate. You must contact the patient's other insur refund any excess it may have paid due to its erroneous primary payment.** *Start: 01/01/1997*
MA18	**Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any qu regarding supplemental benefits to them.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA19	**Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submit concerning that insurer. Please verify your information and submit your secondary claim directly to that** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA20	**Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral ca convenience or the control of incontinence.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
MA21	**SSA records indicate mismatch with name and sex.** *Start: 01/01/1997*
MA22	**Payment of less than $1.00 suppressed.** *Start: 01/01/1997*

MA23	**Demand bill approved as result of medical review.** *Start: 01/01/1997*
MA24	**Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
MA25	**A patient may not elect to change a hospice provider more than once in a benefit period.** *Start: 01/01/1997*
MA26	**Alert: Our records indicate that you were previously informed of this rule.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA27	**Missing/incomplete/invalid entitlement number or name shown on the claim.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA28	**Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information does not make the physician or supplier a party to the determination. No additional rights to appeal thi above those rights already provided for by regulation/instruction, are conferred by receipt of this notic** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA30	**Missing/incomplete/invalid type of bill.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA31	**Missing/incomplete/invalid beginning and ending dates of the period billed.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA32	**Missing/incomplete/invalid number of covered days during the billing period.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA33	**Missing/incomplete/invalid non-covered days during the billing period.** *Start: 01/01/1997 | Last Modified: 03/01/2022* *Notes: (Modified 2/28/03, 3/1/2022)*
MA34	**Missing/incomplete/invalid number of coinsurance days during the billing period.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*

MA35	**Missing/incomplete/invalid number of lifetime reserve days.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA36	**Missing/incomplete/invalid patient name.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA37	**Missing/incomplete/invalid patient's address.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA39	**Missing/incomplete/invalid gender.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA40	**Missing/incomplete/invalid admission date.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA41	**Missing/incomplete/invalid admission type.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA42	**Missing/incomplete/invalid admission source.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA43	**Missing/incomplete/invalid patient status.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA44	**Alert: No appeal rights. Adjudicative decision based on law.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA45	**Alert: As previously advised, a portion or all of your payment is being held in a special account.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA46	**Alert: The new information was considered but additional payment will not be issued.** *Start: 01/01/1997 | Last Modified: 11/01/2015* *Notes: (Modified 3/1/2009, 11/1/2015)*

MA47	**Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for pay** *Start: 01/01/1997*
MA48	**Missing/incomplete/invalid name or address of responsible party or primary payer.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA50	**Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.** *Start: 01/01/1997 | Last Modified: 03/01/2014* *Notes: (Modified 2/28/03, 3/1/2014)*
MA53	**Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.** *Start: 01/01/1997 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04)*
MA54	**Physician certification or election consent for hospice care not received timely.** *Start: 01/01/1997*
MA55	**Not covered as patient received medical health care services, automatically revoking his/her election to religious non-medical health care services.** *Start: 01/01/1997*
MA56	**Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for pay under Federal law, you cannot charge the patient more than the limiting charge amount.** *Start: 01/01/1997*
MA57	**Patient submitted written request to revoke his/her election for religious non-medical health care servi** *Start: 01/01/1997*
MA58	**Missing/incomplete/invalid release of information indicator.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA59	**Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days fo difference between his/her payment and the total amount shown as patient responsibility on this notic** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA60	**Missing/incomplete/invalid patient relationship to insured.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*

MA61	**Missing/incomplete/invalid social security number.** *Start: 01/01/1997 | Last Modified: 03/01/2018* *Notes: (Modified 2/28/03, 3/1/2018)*
MA62	**Alert: This is a telephone review decision.** *Start: 01/01/1997 | Last Modified: 08/01/2007* *Notes: (Modified 4/1/07, 8/1/07)*
MA63	**Missing/incomplete/invalid principal diagnosis.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA64	**Our records indicate that we should be the third payer for this claim. We cannot process this claim until received payment information from the primary and secondary payers.** *Start: 01/01/1997*
MA65	**Missing/incomplete/invalid admitting diagnosis.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA66	**Missing/incomplete/invalid principal procedure code.** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N303*
MA67	**Alert: Correction to a prior claim.** *Start: 01/01/1997 | Last Modified: 11/01/2015* *Notes: (Modified 11/1/2015)*
MA68	**Alert: We did not crossover this claim because the secondary insurance information on the claim was in Please supply complete information or use the PLANID of the insurer to assure correct and timely routi claim.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA69	**Missing/incomplete/invalid remarks.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA70	**Missing/incomplete/invalid provider representative signature.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA71	**Missing/incomplete/invalid provider representative signature date.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*

MA72	**Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 3 the difference between his/her payment to you and the total of the amount shown as patient responsi paid to the patient on this notice.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA73	**Informational remittance associated with a Medicare demonstration. No payment issued under fee-for- Medicare as patient has elected managed care.** *Start: 01/01/1997*
MA74	**Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returne** *Start: 01/01/1997 | Last Modified: 07/01/2015* *Notes: (Modified 7/1/15)*
MA75	**Missing/incomplete/invalid patient or authorized representative signature.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA76	**Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is pe care plan oversight services.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03, 2/1/04)*
MA77	**Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference b patient's payment less the total of our and other payer payments and the amount shown as patient res on this notice.** *Start: 01/01/1997 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
MA79	**Billed in excess of interim rate.** *Start: 01/01/1997*
MA80	**Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital intermediary for all services for this encounter under a demonstration project.** *Start: 01/01/1997*
MA81	**Missing/incomplete/invalid provider/supplier signature.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA83	**Did not indicate whether we are the primary or secondary payer.** *Start: 01/01/1997 | Last Modified: 08/01/2005* *Notes: (Modified 8/1/05)*

MA84	**Patient identified as participating in the National Emphysema Treatment Trial but our records indicate t patient is either not a participant, or has not yet been approved for this phase of the study. Contact Joh University, the study coordinator, to resolve if there was a discrepancy.** *Start: 01/01/1997*
MA88	**Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA89	**Missing/incomplete/invalid patient's relationship to the insured for the primary payer.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA90	**Missing/incomplete/invalid employment status code for the primary insured.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03).*
MA91	**Alert: This determination is the result of the appeal you filed.** *Start: 01/01/1997 | Last Modified: 07/01/2015* *Notes: (Modified 7/1/15)*
MA92	**Missing plan information for other insurance.** *Start: 01/01/1997 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04) Related to N245*
MA93	**Non-PIP (Periodic Interim Payment) claim.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
MA94	**Did not enter the statement 'Attending physician not hospice employee' on the claim form to certify tha rendering physician is not an employee of the hospice.** *Start: 01/01/1997 | Last Modified: 08/01/2005* *Notes: (Reactivated 4/1/04, Modified 8/1/05)*
MA96	**Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Med managed care plan.** *Start: 01/01/1997*
MA97	**Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial re number.** *Start: 01/01/1997 | Last Modified: 02/29/2008* *Notes: (Modified 2/29/08)*

MA99	**Missing/incomplete/invalid Medigap information.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA100	**Missing/incomplete/invalid date of current illness or symptoms.** *Start: 01/01/1997 | Last Modified: 03/14/2014* *Notes: (Modified 2/28/03, 3/30/05, 3/14/2014)*
MA103	**Hemophilia Add On.** *Start: 01/01/1997*
MA106	**PIP (Periodic Interim Payment) claim.** *Start: 01/01/1997 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
MA107	**Paper claim contains more than three separate data items in field 19.** *Start: 01/01/1997*
MA108	**Paper claim contains more than one data item in field 23.** *Start: 01/01/1997*
MA109	**Claim processed in accordance with ambulatory surgical guidelines.** *Start: 01/01/1997*
MA110	**Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outsid if no purchased tests are included on the claim.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA111	**Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA112	**Missing/incomplete/invalid group practice information.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA113	**Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Ser claims cannot be processed without your correct TIN, and you may not bill the patient pending correcti TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you hav this office of your correct TIN.** *Start: 01/01/1997*

MA114	**Missing/incomplete/invalid information on where the services were furnished.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA115	**Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were ren Health Professional Shortage Area (HPSA).** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA116	**Did not complete the statement 'Homebound' on the claim to validate whether laboratory services wer performed at home or in an institution.** *Start: 01/01/1997* *Notes: (Reactivated 4/1/04)*
MA117	**This claim has been assessed a $1.00 user fee.** *Start: 01/01/1997*
MA118	**Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligib through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.** *Start: 01/01/1997 | Last Modified: 11/01/2014*
MA120	**Missing/incomplete/invalid CLIA certification number.** *Start: 01/01/1997 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
MA121	**Missing/incomplete/invalid x-ray date.** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04)*
MA122	**Missing/incomplete/invalid initial treatment date.** *Start: 01/01/1997 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04)*
MA123	**Your center was not selected to participate in this study, therefore, we cannot pay for these services.** *Start: 01/01/1997*
MA125	**Per legislation governing this program, payment constitutes payment in full.** *Start: 01/01/1997*
MA126	**Pancreas transplant not covered unless kidney transplant performed.** *Start: 10/12/2001*

MA128	**Missing/incomplete/invalid FDA approval number.** *Start: 10/12/2001 | Last Modified: 03/30/2005* *Notes: (Modified 2/28/03, 3/30/05)*
MA130	**Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because t unprocessable. Please submit a new claim with the complete/correct information.** *Start: 10/12/2001*
MA131	**Physician already paid for services in conjunction with this demonstration claim. You must have the phy withdraw that claim and refund the payment before we can process your claim.** *Start: 10/12/2001*
MA132	**Adjustment to the pre-demonstration rate.** *Start: 10/12/2001*
MA133	**Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.** *Start: 10/12/2001*
MA134	**Missing/incomplete/invalid provider number of the facility where the patient resides.** *Start: 10/12/2001*
N1	**Alert: You may appeal this decision in writing within the required time limits following receipt of this no following the instructions included in your contract, plan benefit documents or jurisdiction statutes. Re URL provided in the ERA for the payer website to access the appeals process guidelines.** *Start: 01/01/2000 | Last Modified: 07/01/2018* *Notes: (Modified 2/28/03, 4/1/07, 7/15/13, 7/1/18)*
N2	**This allowance has been made in accordance with the most appropriate course of treatment provision** *Start: 01/01/2000*
N3	**Missing consent form.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03) Related to N228*
N4	**Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.** *Start: 01/01/2000 | Last Modified: 03/06/2012* *Notes: (Modified 2/28/03, 3/6/2012)*
N5	**EOB received from previous payer. Claim not on file.** *Start: 01/01/2000*
N6	**Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare wou allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.**

	Start: 01/01/2000 | Last Modified: 02/28/2003 *Notes: (Modified 2/28/03)*
N7	**Alert: Processing of this claim/service has included consideration under Major Medical provisions.** *Start: 01/01/2000 | Last Modified: 07/15/2013* *Notes: (Modified 7/15/13)*
N8	**Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim payer to provide adequate data for adjudication.** *Start: 01/01/2000*
N9	**Adjustment represents the estimated amount a previous payer may pay.** *Start: 01/01/2000 | Last Modified: 11/18/2005* *Notes: (Modified 11/18/05)*
N10	**Adjustment based on the findings of a review organization/professional consult/manual adjudication/r advisor/dental advisor/peer review.** *Start: 01/01/2000 | Last Modified: 03/01/2015* *Notes: (Modified 10/31/02, 7/1/08, 7/15/13, 3/1/2015)*
N11	**Denial reversed because of medical review.** *Start: 01/01/2000*
N12	**Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in t applicable part of Medicare, the member is responsible for payment of the portion of the charge that w been covered by Medicare.** *Start: 01/01/2000 | Last Modified: 08/01/2007* *Notes: (Modified 8/1/07)*
N13	**Payment based on professional/technical component modifier(s).** *Start: 01/01/2000*
N15	**Services for a newborn must be billed separately.** *Start: 01/01/2000*
N16	**Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.** *Start: 01/01/2000*
N19	**Procedure code incidental to primary procedure.** *Start: 01/01/2000*
N20	**Service not payable with other service rendered on the same date.** *Start: 01/01/2000*

N21	**Alert: Your line item has been separated into multiple lines to expedite handling.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 8/1/05, 4/1/07)*
N22	**Alert: This procedure code was added/changed because it more accurately describes the services rende** *Start: 01/01/2000 | Last Modified: 07/01/2015* *Notes: (Modified 10/31/02, 2/28/03, 7/1/15)*
N23	**Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maxim provisions.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 8/13/01, 4/1/07)*
N24	**Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N25	**This company has been contracted by your benefit plan to provide administrative claims payment servi This company does not assume financial risk or obligation with respect to claims processed on behalf o benefit plan.** *Start: 01/01/2000*
N26	**Missing itemized bill/statement.** *Start: 01/01/2000 | Last Modified: 07/01/2008* *Notes: (Modified 2/28/03, 7/1/2008) Related to N232*
N27	**Missing/incomplete/invalid treatment number.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N28	**Consent form requirements not fulfilled.** *Start: 01/01/2000*
N30	**Patient ineligible for this service.** *Start: 01/01/2000 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
N31	**Missing/incomplete/invalid prescribing provider identifier.** *Start: 01/01/2000 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04)*
N32	**Claim must be submitted by the provider who rendered the service.** *Start: 01/01/2000 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*

N33	**No record of health check prior to initiation of treatment.** *Start: 01/01/2000*
N34	**Incorrect claim form/format for this service.** *Start: 01/01/2000 | Last Modified: 11/18/2005* *Notes: (Modified 11/18/05)*
N35	**Program integrity/utilization review decision.** *Start: 01/01/2000*
N36	**Claim must meet primary payer's processing requirements before we can consider payment.** *Start: 01/01/2000*
N37	**Missing/incomplete/invalid tooth number/letter.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N39	**Procedure code is not compatible with tooth number/letter.** *Start: 01/01/2000*
N40	**Missing radiology film(s)/image(s).** *Start: 01/01/2000 | Last Modified: 07/01/2008* *Notes: (Modified 2/1/04, 7/1/08) Related to N242*
N42	**Missing mental health assessment.** *Start: 01/01/2000 | Last Modified: 11/01/2014*
N43	**Bed hold or leave days exceeded.** *Start: 01/01/2000*
N45	**Payment based on authorized amount.** *Start: 01/01/2000*
N46	**Missing/incomplete/invalid admission hour.** *Start: 01/01/2000*
N47	**Claim conflicts with another inpatient stay.** *Start: 01/01/2000*
N48	**Claim information does not agree with information received from other insurance carrier.** *Start: 01/01/2000*
N49	**Court ordered coverage information needs validation.** *Start: 01/01/2000*

N50	**Missing/incomplete/invalid discharge information.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N51	**Electronic interchange agreement not on file for provider/submitter.** *Start: 01/01/2000*
N52	**Patient not enrolled in the billing provider's managed care plan on the date of service.** *Start: 01/01/2000*
N53	**Missing/incomplete/invalid point of pick-up address.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N54	**Claim information is inconsistent with pre-certified/authorized services.** *Start: 01/01/2000*
N55	**Procedures for billing with group/referring/performing providers were not followed.** *Start: 01/01/2000*
N56	**Procedure code billed is not correct/valid for the services billed or the date of service billed.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N57	**Missing/incomplete/invalid prescribing date.** *Start: 01/01/2000 | Last Modified: 12/02/2004* *Notes: (Modified 12/2/04) Related to N304*
N58	**Missing/incomplete/invalid patient liability amount.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N59	**Alert: Please refer to your provider manual for additional program and provider information.** *Start: 01/01/2000 | Last Modified: 11/01/2015* *Notes: (Modified 4/1/07, 11/1/09, 11/1/2015)*
N61	**Rebill services on separate claims.** *Start: 01/01/2000*
N62	**Dates of service span multiple rate periods. Resubmit separate claims.** *Start: 01/01/2000 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*

N63	**Rebill services on separate claim lines.** *Start: 01/01/2000*
N64	**The 'from' and 'to' dates must be different.** *Start: 01/01/2000*
N65	**Procedure code or procedure rate count cannot be determined, or was not on file, for the date of servic** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N67	**Professional provider services not paid separately. Included in facility payment under a demonstration p Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was exc this demonstration; or if you furnished these services in another location on the date of the patient's ad discharge from a demonstration hospital. If services were furnished in a facility not involved in the dem on the same date the patient was discharged from or admitted to a demonstration facility, you must re provider ID number for the non-demonstration facility on the new claim.** *Start: 01/01/2000*
N68	**Prior payment being cancelled as we were subsequently notified this patient was covered by a demonst project in this site of service. Professional services were included in the payment made to the facility. Y contact the facility for your payment. Prior payment made to you by the patient or another insurer for t must be refunded to the payer within 30 days.** *Start: 01/01/2000*
N69	**Alert: PPS (Prospective Payment System) code changed by claims processing system.** *Start: 01/01/2000 | Last Modified: 11/01/2015* *Notes: (Modified 6/30/03, 7/1/12, 11/1/2015)*
N70	**Consolidated billing and payment applies.** *Start: 01/01/2000 | Last Modified: 11/05/2007* *Notes: (Modified 2/28/02, 11/5/07)*
N71	**Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance servi processed as an assigned claim. You are required by law to accept assignment for these types of claims.** *Start: 01/01/2000 | Last Modified: 06/30/2003* *Notes: (Modified 2/21/02, 6/30/03)*
N72	**PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical record** *Start: 01/01/2000 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
N74	**Resubmit with multiple claims, each claim covering services provided in only one calendar month.** *Start: 01/01/2000*

N75	**Missing/incomplete/invalid tooth surface information.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N76	**Missing/incomplete/invalid number of riders.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N77	**Missing/incomplete/invalid designated provider number.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N78	**The necessary components of the child and teen checkup (EPSDT) were not completed.** *Start: 01/01/2000*
N79	**Service billed is not compatible with patient location information.** *Start: 01/01/2000*
N80	**Missing/incomplete/invalid prenatal screening information.** *Start: 01/01/2000 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N81	**Procedure billed is not compatible with tooth surface code.** *Start: 01/01/2000*
N82	**Provider must accept insurance payment as payment in full when a third party payer contract specifies reimbursement.** *Start: 01/01/2000*
N83	**No appeal rights. Adjudicative decision based on the provisions of a demonstration project.** *Start: 01/01/2000*
N84	**Alert: Further installment payments are forthcoming.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07, 8/1/07)*
N85	**Alert: This is the final installment payment.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07, 8/1/07)*
N86	**A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treat urinary incontinence to be covered.** *Start: 01/01/2000*

N87	**Home use of biofeedback therapy is not covered.** *Start: 01/01/2000*
N88	**Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this p When a patient is treated under a HHA episode of care, consolidated billing requires that certain therap and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped fr we establish that the patient is concurrently receiving treatment under a HHA episode of care.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N89	**Alert: Payment information for this claim has been forwarded to more than one other payer, but forma limitations permit only one of the secondary payers to be identified in this remittance advice.** *Start: 01/01/2000 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N90	**Covered only when performed by the attending physician.** *Start: 01/01/2000*
N91	**Services not included in the appeal review.** *Start: 01/01/2000*
N92	**This facility is not certified for digital mammography.** *Start: 01/01/2000*
N93	**A separate claim must be submitted for each place of service. Services furnished at multiple sites may n in the same claim.** *Start: 01/01/2000*
N94	**Claim/Service denied because a more specific taxonomy code is required for adjudication.** *Start: 01/01/2000*
N95	**This provider type/provider specialty may not bill this service.** *Start: 07/31/2001 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N96	**Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or sur corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia ca** *Start: 08/24/2001*
N97	**Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes w peripheral nerve involvement) which are associated with secondary manifestations of the above three i are excluded.** *Start: 08/24/2001*

N98	**Patient must have had a successful test stimulation in order to support subsequent implantation. Befor is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement test stimulation. Improvement is measured through voiding diaries.** *Start: 08/24/2001*
N99	**Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical resu implant procedure can be properly evaluated.** *Start: 08/24/2001*
N103	**Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when th was rendered. This payer does not cover items and services furnished to an individual while he or she is under a penal statute or rule, unless under State or local law, the individual is personally liable for the c or her health care while in custody and the State or local government pursues the collection of such del same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.** *Start: 10/31/2001 | Last Modified: 11/01/2013* *Notes: (Modified 6/30/03, 7/1/12, 11/1/13)*
N104	**This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medica contractor to process this claim/service through the CMS website at www.cms.gov.** *Start: 01/29/2002 | Last Modified: 07/01/2010* *Notes: (Modified 10/31/02, 7/1/10)*
N105	**This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palm P.O. Box 10066, Augusta, GA 30999. Call 888-355-9165 for RRB EDI information for electronic claims pro** *Start: 01/29/2002 | Last Modified: 07/01/2017* *Notes: (Modified 7/1/2017)*
N106	**Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) be made to the SNF. You must request payment from the SNF rather than the patient for this service.** *Start: 01/31/2002*
N107	**Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They billed separately as outpatient services.** *Start: 01/31/2002*
N108	**Missing/incomplete/invalid upgrade information.** *Start: 01/31/2002 | Last Modified: 02/28/2003* *Notes: (Modified 2/28/03)*
N109	**Alert: This claim/service was chosen for complex review.** *Start: 02/28/2002 | Last Modified: 07/01/2015* *Notes: (Modified 3/1/2009, 7/1/15)*

N110	**This facility is not certified for film mammography.** *Start: 02/28/2002*
N111	**No appeal right except duplicate claim/service issue. This service was included in a claim that has been billed and adjudicated.** *Start: 02/28/2002*
N112	**This claim is excluded from your electronic remittance advice.** *Start: 02/28/2002*
N113	**Only one initial visit is covered per physician, group practice or provider.** *Start: 04/16/2002 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
N114	**During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amo calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitte for the service. You will be notified yearly what the percentages for the blended payment calculation w** *Start: 05/30/2002*
N115	**This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in d whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, not have web access, you may contact the contractor to request a copy of the LCD.** *Start: 05/30/2002 | Last Modified: 07/01/2010* *Notes: (Modified 4/1/04, 7/1/10)*
N116	**Alert: This payment is being made conditionally because the service was provided in the home, and it is that the patient is under a home health episode of care. When a patient is treated under a home health care, consolidated billing requires that certain therapy services and supplies, such as this, be included in health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that is concurrently receiving treatment under an HHA episode of care.** *Start: 06/30/2002 | Last Modified: 11/01/2016* *Notes: (Modified 11/1/2016)*
N117	**This service is paid only once in a patient's lifetime.** *Start: 07/30/2002 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
N118	**This service is not paid if billed more than once every 28 days.** *Start: 07/30/2002*
N119	**This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive da inpatient or Skilled /nursing Facility (SNF) within those 28 days.** *Start: 07/30/2002 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*

N120	**Payment is subject to home health prospective payment system partial episode payment adjustment. P transferred/discharged/readmitted during payment episode.** *Start: 08/09/2002 | Last Modified: 06/30/2003* *Notes: (Modified 6/30/03)*
N121	**Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries Medicare Part A covered Skilled Nursing Facility (SNF) stay.** *Start: 09/09/2002 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04, 6/30/03)*
N122	**Add-on code cannot be billed by itself.** *Start: 09/12/2002 | Last Modified: 08/01/2005* *Notes: (Modified 8/1/05)*
N123	**Alert: This is a split service and represents a portion of the units from the originally submitted service.** *Start: 09/24/2002 | Last Modified: 03/01/2016* *Notes: (Modified 3/1/2016)*
N124	**Payment has been denied for the/made only for a less extensive service/item because the information does not substantiate the need for the (more extensive) service/item. The patient is liable for the charg service/item as you informed the patient in writing before the service/item was furnished that we wou for it, and the patient agreed to pay.** *Start: 09/26/2002*
N125	**Payment has been (denied for the/made only for a less extensive) service/item because the informatio does not substantiate the need for the (more extensive) service/item. If you have collected any amount patient, you must refund that amount to the patient within 30 days of receiving this notice.** **The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 18 cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and w to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medica program. If you have any questions about this notice, please contact this office.** *Start: 09/26/2002 | Last Modified: 08/01/2005* *Notes: (Modified 8/1/05. Also refer to N356)*
N126	**Social Security Records indicate that this individual has been deported. This payer does not cover items services furnished to individuals who have been deported.** *Start: 10/17/2002*
N127	**This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please s claims to them.** *Start: 10/31/2007 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04*

N128	**This amount represents the prior to coverage portion of the allowance.** *Start: 10/31/2002*
N129	**Not eligible due to the patient's age.** *Start: 10/31/2002 | Last Modified: 08/01/2007* *Notes: (Modified 8/1/07)*
N130	**Consult plan benefit documents/guidelines for information about restrictions for this service.** *Start: 10/31/2002 | Last Modified: 11/01/2009* *Notes: (Modified 4/1/07, 7/1/08, 11/1/09)*
N131	**Total payments under multiple contracts cannot exceed the allowance for this service.** *Start: 10/31/2002*
N132	**Alert: Payments will cease for services rendered by this US Government debarred or excluded provider 30 day grace period as previously notified.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N133	**Alert: Services for predetermination and services requesting payment are being processed separately.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N134	**Alert: This represents your scheduled payment for this service. If treatment has been discontinued, plea Customer Service.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N135	**Record fees are the patient's responsibility and limited to the specified co-payment.** *Start: 10/31/2002*
N136	**Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consume Assistance Office at (602) 912-8444 or (800) 325-2548.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N137	**Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acti Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing if the coverage decision involves an urgent condition for which care has not been rendered. The addres obtained from the State Insurance Regulatory Authority.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 8/1/04, 2/28/03, 4/1/07)*
N138	**Alert: In the event you disagree with the Dental Advisor's opinion and have additional information rela case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrie**

	second Independent Dental Advisor Review. *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N139	**Alert: Under 32 CFR 199.13, a non-participating provider is not an appropriate appealing party. Therefo disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, b beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a cop letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevar information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.** *Start: 10/31/2002 | Last Modified: 03/01/2017* *Notes: (Modified 4/1/07, 3/1/2017)*
N140	**Alert: You have not been designated as an authorized OCONUS provider therefore are not considered a appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her represen you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a sig statement explaining the matter in which you disagree, and any relevant information to the subscriber' insurance carrier within 90 days from the date of this letter.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N141	**The patient was not residing in a long-term care facility during all or part of the service dates billed.** *Start: 10/31/2002*
N142	**The original claim was denied. Resubmit a new claim, not a replacement claim.** *Start: 10/31/2002*
N143	**The patient was not in a hospice program during all or part of the service dates billed.** *Start: 10/31/2002*
N144	**The rate changed during the dates of service billed.** *Start: 10/31/2002*
N146	**Missing screening document.** *Start: 10/31/2002 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04) Related to N243*
N147	**Long term care case mix or per diem rate cannot be determined because the patient ID number is missi incomplete, or invalid on the assignment request.** *Start: 10/31/2002*
N148	**Missing/incomplete/invalid date of last menstrual period.** *Start: 10/31/2002*
N149	**Rebill all applicable services on a single claim.** *Start: 10/31/2002*

N150	**Missing/incomplete/invalid model number.** *Start: 10/31/2002*
N151	**Telephone contact services will not be paid until the face-to-face contact requirement has been met.** *Start: 10/31/2002*
N152	**Missing/incomplete/invalid replacement claim information.** *Start: 10/31/2002*
N153	**Missing/incomplete/invalid room and board rate.** *Start: 10/31/2002*
N154	**Alert: This payment was delayed for correction of provider's mailing address.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N155	**Alert: Our records do not indicate that other insurance is on file. Please submit other insurance informa our records.** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N156	**Alert: The patient is responsible for the difference between the approved treatment and the elective tr** *Start: 10/31/2002 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N157	**Transportation to/from this destination is not covered.** *Start: 02/28/2003 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04)*
N158	**Transportation in a vehicle other than an ambulance is not covered.** *Start: 02/28/2003*
N159	**Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.** *Start: 02/28/2003*
N160	**The patient must choose an option before a payment can be made for this procedure/ equipment/ sup service.** *Start: 02/28/2003 | Last Modified: 02/01/2004* *Notes: (Modified 2/1/04)*
N161	**This drug/service/supply is covered only when the associated service is covered.** *Start: 02/28/2003*
N162	**Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of pay**

	the near future. *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N163	**Medical record does not support code billed per the code definition.** *Start: 02/28/2003*
N167	**Charges exceed the post-transplant coverage limit.** *Start: 02/28/2003*
N170	**A new/revised/renewed certificate of medical necessity is needed.** *Start: 02/28/2003*
N171	**Payment for repair or replacement is not covered or has exceeded the purchase price.** *Start: 02/28/2003*
N172	**The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.** *Start: 02/28/2003*
N173	**No qualifying hospital stay dates were provided for this episode of care.** *Start: 02/28/2003*
N174	**This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amount the adjustments under group 'PR'.** *Start: 02/28/2003*
N175	**Missing review organization approval.** *Start: 02/28/2003 | Last Modified: 02/29/2008* *Notes: (Modified 8/1/04, 2/29/08) Related to N241*
N176	**Services provided aboard a ship are covered only when the ship is of United States registry and is in Uni waters. In addition, a doctor licensed to practice in the United States must provide the service.** *Start: 02/28/2003*
N177	**Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment made.** *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 6/30/03, 4/1/07)*
N178	**Missing pre-operative images/visual field results.** *Start: 02/28/2003 | Last Modified: 11/01/2013* *Notes: (Modified 8/1/04, 11/1/13) Related to N244*

N179	**Additional information has been requested from the member. The charges will be reconsidered upon re that information.** *Start: 02/28/2003*
N180	**This item or service does not meet the criteria for the category under which it was billed.** *Start: 02/28/2003*
N181	**Additional information is required from another provider involved in this service.** *Start: 02/28/2003 | Last Modified: 12/01/2006* *Notes: (Modified 12/1/06)*
N182	**This claim/service must be billed according to the schedule for this plan.** *Start: 02/28/2003*
N183	**Alert: This is a predetermination advisory message, when this service is submitted for payment additio documentation as specified in plan documents will be required to process benefits.** *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N184	**Rebill technical and professional components separately.** *Start: 02/28/2003*
N185	**Alert: Do not resubmit this claim/service.** *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N186	**Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facil for assistance.** *Start: 02/28/2003*
N187	**Alert: You may request a review in writing within the required time limits following receipt of this notic following the instructions included in your contract or plan benefit documents.** *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N188	**The approved level of care does not match the procedure code submitted.** *Start: 02/28/2003*
N189	**Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.** *Start: 02/28/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*

N190	**Missing contract indicator.** *Start: 02/28/2003 | Last Modified: 08/01/2004* *Notes: (Modified 8/1/04) Related to N229*
N191	**The provider must update insurance information directly with payer.** *Start: 02/28/2003*
N192	**Alert: Patient is a Medicaid/Qualified Medicare Beneficiary.** *Start: 02/28/2003 | Last Modified: 07/01/2020*
N193	**Alert: Specific federal/state/local program may cover this service through another payer.** *Start: 02/28/2003 | Last Modified: 11/01/2015* *Notes: (Modified 11/1/2015)*
N194	**Technical component not paid if provider does not own the equipment used.** *Start: 02/25/2003*
N195	**The technical component must be billed separately.** *Start: 02/25/2003*
N196	**Alert: Patient eligible to apply for other coverage which may be primary.** *Start: 02/25/2003 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N197	**The subscriber must update insurance information directly with payer.** *Start: 02/25/2003*
N198	**Rendering provider must be affiliated with the pay-to provider.** *Start: 02/25/2003*
N199	**Additional payment/recoupment approved based on payer-initiated review/audit.** *Start: 02/25/2003 | Last Modified: 08/01/2006* *Notes: (Modified 8/1/06)*
N200	**The professional component must be billed separately.** *Start: 02/25/2003*
N202	**Alert: Additional information/explanation will be sent separately.** *Start: 06/30/2003 | Last Modified: 11/01/2015* *Notes: (Modified 4/1/07, 11/1/09, 3/14/2014, 11/1/2015)*
N203	**Missing/incomplete/invalid anesthesia time/units.** *Start: 06/30/2003 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*

N204	**Services under review for possible pre-existing condition. Send medical records for prior 12 months** *Start: 06/30/2003*
N205	**Information provided was illegible.** *Start: 06/30/2003 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N206	**The supporting documentation does not match the information sent on the claim.** *Start: 06/30/2003 | Last Modified: 03/06/2012* *Notes: (Modified 3/6/12)*
N207	**Missing/incomplete/invalid weight.** *Start: 06/30/2003 | Last Modified: 11/18/2005* *Notes: (Modified 11/18/05)*
N208	**Missing/incomplete/invalid DRG code.** *Start: 06/30/2003 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N209	**Missing/incomplete/invalid taxpayer identification number (TIN).** *Start: 06/30/2003 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N210	**Alert: You may appeal this decision.** *Start: 06/30/2003 | Last Modified: 03/14/2014* *Notes: (Modified 4/1/07, 3/14/2014)*
N211	**Alert: You may not appeal this decision.** *Start: 06/30/2003 | Last Modified: 03/14/2014* *Notes: (Modified 4/1/07, 3/14/2014)*
N212	**Charges processed under a Point of Service benefit.** *Start: 02/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N213	**Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.** *Start: 04/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N214	**Missing/incomplete/invalid history of the related initial surgical procedure(s).** *Start: 04/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N215	**Alert: A payer providing supplemental or secondary coverage shall not require a claims determination f service from a primary payer as a condition of making its own claims determination.**

	Start: 04/01/2004 | Last Modified: 04/01/2007 *Notes: (Modified 4/1/07)*
N216	**We do not offer coverage for this type of service or the patient is not enrolled in this portion of our ben package.** *Start: 04/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/1/2010, 3/14/2014)*
N217	**We pay only one site of service per provider per claim.** *Start: 08/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N218	**You must furnish and service this item for as long as the patient continues to need it. We can pay for ma and/or servicing for the time period specified in the contract or coverage manual.** *Start: 08/01/2004*
N219	**Payment based on previous payer's allowed amount.** *Start: 08/01/2004*
N220	**Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.** *Start: 08/01/2004 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N221	**Missing Admitting History and Physical report.** *Start: 08/01/2004*
N222	**Incomplete/invalid Admitting History and Physical report.** *Start: 08/01/2004*
N223	**Missing documentation of benefit to the patient during initial treatment period.** *Start: 08/01/2004*
N224	**Incomplete/invalid documentation of benefit to the patient during initial treatment period.** *Start: 08/01/2004*
N226	**Incomplete/invalid American Diabetes Association Certificate of Recognition.** *Start: 08/01/2004*
N227	**Incomplete/invalid Certificate of Medical Necessity.** *Start: 08/01/2004*
N228	**Incomplete/invalid consent form.** *Start: 08/01/2004*

N229	**Incomplete/invalid contract indicator.** *Start: 08/01/2004*
N230	**Incomplete/invalid indication of whether the patient owns the equipment that requires the part or sup** *Start: 08/01/2004*
N231	**Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the intraocular lens used.** *Start: 08/01/2004*
N232	**Incomplete/invalid itemized bill/statement.** *Start: 08/01/2004 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N233	**Incomplete/invalid operative note/report.** *Start: 08/01/2004 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N234	**Incomplete/invalid oxygen certification/re-certification.** *Start: 08/01/2004*
N235	**Incomplete/invalid pacemaker registration form.** *Start: 08/01/2004*
N236	**Incomplete/invalid pathology report.** *Start: 08/01/2004*
N237	**Incomplete/invalid patient medical record for this service.** *Start: 08/01/2004*
N238	**Incomplete/invalid physician certified plan of care.** *Start: 08/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N239	**Incomplete/invalid physician financial relationship form.** *Start: 08/01/2004*
N240	**Incomplete/invalid radiology report.** *Start: 08/01/2004*
N241	**Incomplete/invalid review organization approval.** *Start: 08/01/2004 | Last Modified: 02/29/2008* *Notes: (Modified 2/29/08)*

N242	**Incomplete/invalid radiology film(s)/image(s).** *Start: 08/01/2004 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N243	**Incomplete/invalid/not approved screening document.** *Start: 08/01/2004*
N244	**Incomplete/Invalid pre-operative images/visual field results.** *Start: 08/01/2004 | Last Modified: 11/01/2013* *Notes: (Modified 11/1/2013)*
N245	**Incomplete/invalid plan information for other insurance.** *Start: 08/01/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N246	**State regulated patient payment limitations apply to this service.** *Start: 12/02/2004*
N247	**Missing/incomplete/invalid assistant surgeon taxonomy.** *Start: 12/02/2004*
N248	**Missing/incomplete/invalid assistant surgeon name.** *Start: 12/02/2004*
N249	**Missing/incomplete/invalid assistant surgeon primary identifier.** *Start: 12/02/2004*
N250	**Missing/incomplete/invalid assistant surgeon secondary identifier.** *Start: 12/02/2004*
N251	**Missing/incomplete/invalid attending provider taxonomy.** *Start: 12/02/2004*
N252	**Missing/incomplete/invalid attending provider name.** *Start: 12/02/2004*
N253	**Missing/incomplete/invalid attending provider primary identifier.** *Start: 12/02/2004*
N254	**Missing/incomplete/invalid attending provider secondary identifier.** *Start: 12/02/2004*
N255	**Missing/incomplete/invalid billing provider taxonomy.** *Start: 12/02/2004*

N256	**Missing/incomplete/invalid billing provider/supplier name.** *Start: 12/02/2004*
N257	**Missing/incomplete/invalid billing provider/supplier primary identifier.** *Start: 12/02/2004*
N258	**Missing/incomplete/invalid billing provider/supplier address.** *Start: 12/02/2004*
N259	**Missing/incomplete/invalid billing provider/supplier secondary identifier.** *Start: 12/02/2004*
N260	**Missing/incomplete/invalid billing provider/supplier contact information.** *Start: 12/02/2004*
N261	**Missing/incomplete/invalid operating provider name.** *Start: 12/02/2004*
N262	**Missing/incomplete/invalid operating provider primary identifier.** *Start: 12/02/2004*
N263	**Missing/incomplete/invalid operating provider secondary identifier.** *Start: 12/02/2004*
N264	**Missing/incomplete/invalid ordering provider name.** *Start: 12/02/2004*
N265	**Missing/incomplete/invalid ordering provider primary identifier.** *Start: 12/02/2004*
N266	**Missing/incomplete/invalid ordering provider address.** *Start: 12/02/2004*
N267	**Missing/incomplete/invalid ordering provider secondary identifier.** *Start: 12/02/2004*
N268	**Missing/incomplete/invalid ordering provider contact information.** *Start: 12/02/2004*
N269	**Missing/incomplete/invalid other provider name.** *Start: 12/02/2004*
N270	**Missing/incomplete/invalid other provider primary identifier.** *Start: 12/02/2004*

N271	**Missing/incomplete/invalid other provider secondary identifier.** *Start: 12/02/2004*
N272	**Missing/incomplete/invalid other payer attending provider identifier.** *Start: 12/02/2004*
N273	**Missing/incomplete/invalid other payer operating provider identifier.** *Start: 12/02/2004*
N274	**Missing/incomplete/invalid other payer other provider identifier.** *Start: 12/02/2004*
N275	**Missing/incomplete/invalid other payer purchased service provider identifier.** *Start: 12/02/2004*
N276	**Missing/incomplete/invalid other payer referring provider identifier.** *Start: 12/02/2004*
N277	**Missing/incomplete/invalid other payer rendering provider identifier.** *Start: 12/02/2004*
N278	**Missing/incomplete/invalid other payer service facility provider identifier.** *Start: 12/02/2004*
N279	**Missing/incomplete/invalid pay-to provider name.** *Start: 12/02/2004*
N280	**Missing/incomplete/invalid pay-to provider primary identifier.** *Start: 12/02/2004*
N281	**Missing/incomplete/invalid pay-to provider address.** *Start: 12/02/2004*
N282	**Missing/incomplete/invalid pay-to provider secondary identifier.** *Start: 12/02/2004*
N283	**Missing/incomplete/invalid purchased service provider identifier.** *Start: 12/02/2004*
N284	**Missing/incomplete/invalid referring provider taxonomy.** *Start: 12/02/2004*
N285	**Missing/incomplete/invalid referring provider name.** *Start: 12/02/2004*

N286	**Missing/incomplete/invalid referring provider primary identifier.** *Start: 12/02/2004*
N287	**Missing/incomplete/invalid referring provider secondary identifier.** *Start: 12/02/2004*
N288	**Missing/incomplete/invalid rendering provider taxonomy.** *Start: 12/02/2004*
N289	**Missing/incomplete/invalid rendering provider name.** *Start: 12/02/2004*
N290	**Missing/incomplete/invalid rendering provider primary identifier.** *Start: 12/02/2004*
N291	**Missing/incomplete/invalid rendering provider secondary identifier.** *Start: 12/02/2004 | Last Modified: 11/01/2010*
N292	**Missing/incomplete/invalid service facility name.** *Start: 12/02/2004*
N293	**Missing/incomplete/invalid service facility primary identifier.** *Start: 12/02/2004*
N294	**Missing/incomplete/invalid service facility primary address.** *Start: 12/02/2004*
N295	**Missing/incomplete/invalid service facility secondary identifier.** *Start: 12/02/2004*
N296	**Missing/incomplete/invalid supervising provider name.** *Start: 12/02/2004*
N297	**Missing/incomplete/invalid supervising provider primary identifier.** *Start: 12/02/2004*
N298	**Missing/incomplete/invalid supervising provider secondary identifier.** *Start: 12/02/2004*
N299	**Missing/incomplete/invalid occurrence date(s).** *Start: 12/02/2004*
N300	**Missing/incomplete/invalid occurrence span date(s).** *Start: 12/02/2004*

N301	**Missing/incomplete/invalid procedure date(s).** *Start: 12/02/2004*
N302	**Missing/incomplete/invalid other procedure date(s).** *Start: 12/02/2004*
N303	**Missing/incomplete/invalid principal procedure date.** *Start: 12/02/2004*
N304	**Missing/incomplete/invalid dispensed date.** *Start: 12/02/2004*
N305	**Missing/incomplete/invalid injury/accident date.** *Start: 12/02/2004 | Last Modified: 11/01/2016* *Notes: (Modified 11/1/2016)*
N306	**Missing/incomplete/invalid acute manifestation date.** *Start: 12/02/2004*
N307	**Missing/incomplete/invalid adjudication or payment date.** *Start: 12/02/2004*
N308	**Missing/incomplete/invalid appliance placement date.** *Start: 12/02/2004*
N309	**Missing/incomplete/invalid assessment date.** *Start: 12/02/2004*
N310	**Missing/incomplete/invalid assumed or relinquished care date.** *Start: 12/02/2004*
N311	**Missing/incomplete/invalid authorized to return to work date.** *Start: 12/02/2004*
N312	**Missing/incomplete/invalid begin therapy date.** *Start: 12/02/2004*
N313	**Missing/incomplete/invalid certification revision date.** *Start: 12/02/2004*
N314	**Missing/incomplete/invalid diagnosis date.** *Start: 12/02/2004*

N315	**Missing/incomplete/invalid disability from date.** *Start: 12/02/2004*
N316	**Missing/incomplete/invalid disability to date.** *Start: 12/02/2004*
N317	**Missing/incomplete/invalid discharge hour.** *Start: 12/02/2004*
N318	**Missing/incomplete/invalid discharge or end of care date.** *Start: 12/02/2004*
N319	**Missing/incomplete/invalid hearing or vision prescription date.** *Start: 12/02/2004*
N320	**Missing/incomplete/invalid Home Health Certification Period.** *Start: 12/02/2004*
N321	**Missing/incomplete/invalid last admission period.** *Start: 12/02/2004*
N322	**Missing/incomplete/invalid last certification date.** *Start: 12/02/2004*
N323	**Missing/incomplete/invalid last contact date.** *Start: 12/02/2004*
N324	**Missing/incomplete/invalid last seen/visit date.** *Start: 12/02/2004*
N325	**Missing/incomplete/invalid last worked date.** *Start: 12/02/2004*
N326	**Missing/incomplete/invalid last x-ray date.** *Start: 12/02/2004*
N327	**Missing/incomplete/invalid other insured birth date.** *Start: 12/02/2004*
N328	**Missing/incomplete/invalid Oxygen Saturation Test date.** *Start: 12/02/2004*
N329	**Missing/incomplete/invalid patient birth date.** *Start: 12/02/2004*

N330	**Missing/incomplete/invalid patient death date.** *Start: 12/02/2004*
N331	**Missing/incomplete/invalid physician order date.** *Start: 12/02/2004*
N332	**Missing/incomplete/invalid prior hospital discharge date.** *Start: 12/02/2004*
N333	**Missing/incomplete/invalid prior placement date.** *Start: 12/02/2004*
N334	**Missing/incomplete/invalid re-evaluation date.** *Start: 12/02/2004 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N335	**Missing/incomplete/invalid referral date.** *Start: 12/02/2004*
N336	**Missing/incomplete/invalid replacement date.** *Start: 12/02/2004*
N337	**Missing/incomplete/invalid secondary diagnosis date.** *Start: 12/02/2004*
N338	**Missing/incomplete/invalid shipped date.** *Start: 12/02/2004*
N339	**Missing/incomplete/invalid similar illness or symptom date.** *Start: 12/02/2004*
N340	**Missing/incomplete/invalid subscriber birth date.** *Start: 12/02/2004*
N341	**Missing/incomplete/invalid surgery date.** *Start: 12/02/2004*
N342	**Missing/incomplete/invalid test performed date.** *Start: 12/02/2004*
N343	**Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.** *Start: 12/02/2004*

N344	**Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.** *Start: 12/02/2004*
N345	**Date range not valid with units submitted.** *Start: 03/30/2005*
N346	**Missing/incomplete/invalid oral cavity designation code.** *Start: 03/30/2005*
N347	**Your claim for a referred or purchased service cannot be paid because payment has already been made same service to another provider by a payment contractor representing the payer.** *Start: 03/30/2005*
N348	**You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.** *Start: 08/01/2005*
N349	**The administration method and drug must be reported to adjudicate this service.** *Start: 08/01/2005*
N350	**Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an U Report procedure.** *Start: 08/01/2005 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N351	**Service date outside of the approved treatment plan service dates.** *Start: 08/01/2005*
N352	**Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.** *Start: 08/01/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N353	**Alert: Benefits have been estimated, when the actual services have been rendered, additional payment considered based on the submitted claim.** *Start: 08/01/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N354	**Incomplete/invalid invoice.** *Start: 08/01/2005 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N355	**Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and co have reasonably been expected to know, that we would not pay for this service; or - If you notified the writing before providing the service that you believed that we were likely to deny the service, and the p signed a statement agreeing to pay for the service.**

	If you come within either exception, or if you believe the carrier was wrong in its determination that we pay for this service, you should request appeal of this determination within 30 days of the date of this n request for review should include any additional information necessary to support your position. **If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to patient until you receive the results of the review. If the review decision is favorable to you, you do not make any refund. If, however, the review is unfavorable, the law specifies that you must make the refun 15 days of receiving the unfavorable review decision.** **The law also permits you to request an appeal at any time within 120 days of the date you receive this n However, an appeal request that is received more than 30 days after the date of this notice, does not pe to delay making the refund. Regardless of when a review is requested, the patient will be notified that w requested one, and will receive a copy of the determination.** **The patient has received a separate notice of this denial decision. The notice advises that he/she may b to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/ instructs the patient to contact our office if he/she does not hear anything about a refund within 30 day** *Start: 08/01/2005 | Last Modified: 04/01/2007* *Notes: (Modified 11/18/05, Modified 4/1/07)*
N356	**Not covered when performed with, or subsequent to, a non-covered service.** *Start: 08/01/2005 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N357	**Time frame requirements between this service/procedure/supply and a related service/procedure/supp not been met.** *Start: 11/18/2005*
N358	**Alert: This decision may be reviewed if additional documentation as described in the contract or plan be documents is submitted.** *Start: 11/18/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N359	**Missing/incomplete/invalid height.** *Start: 11/18/2005*
N360	**Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determina Submit payment information from the primary payer with the secondary claim.** *Start: 11/18/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N362	**The number of Days or Units of Service exceeds our acceptable maximum.** *Start: 11/18/2005*

N363	**Alert: in the near future we are implementing new policies/procedures that would affect this determina** *Start: 11/18/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N364	**Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.** *Start: 11/18/2005 | Last Modified: 04/01/2007* *Notes: (Modified 4/1/07)*
N366	**Requested information not provided. The claim will be reopened if the information previously requeste submitted within one year after the date of this denial notice.** *Start: 04/01/2006*
N367	**Alert: The claim information has been forwarded to a Consumer Spending Account processor for review example, flexible spending account or health savings account.** *Start: 04/01/2006 | Last Modified: 07/01/2008* *Notes: (Modified 4/1/07, 11/5/07, 7/1/08)*
N368	**You must appeal the determination of the previously adjudicated claim.** *Start: 04/01/2006*
N369	**Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.** *Start: 04/01/2006*
N370	**Billing exceeds the rental months covered/approved by the payer.** *Start: 08/01/2006*
N371	**Alert: title of this equipment must be transferred to the patient.** *Start: 08/01/2006*
N372	**Only reasonable and necessary maintenance/service charges are covered.** *Start: 08/01/2006*
N373	**It has been determined that another payer paid the services as primary when they were not the primar Therefore, we are refunding to the payer that paid as primary on your behalf.** *Start: 12/01/2006*
N374	**Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.** *Start: 12/01/2006*
N375	**Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.** *Start: 12/01/2006*
N376	**Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.** *Start: 12/01/2006*

N377	**Payment based on a processed replacement claim.** *Start: 12/01/2006 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/07)*
N378	**Missing/incomplete/invalid prescription quantity.** *Start: 12/01/2006*
N379	**Claim level information does not match line level information.** *Start: 12/01/2006*
N380	**The original claim has been processed, submit a corrected claim.** *Start: 04/01/2007*
N381	**Alert: Consult our contractual agreement for restrictions/billing/payment information related to these** *Start: 04/01/2007 | Last Modified: 07/01/2015* *Notes: (Modified 7/1/15)*
N382	**Missing/incomplete/invalid patient identifier.** *Start: 04/01/2007*
N383	**Not covered when deemed cosmetic.** *Start: 04/01/2007 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N384	**Records indicate that the referenced body part/tooth has been removed in a previous procedure.** *Start: 04/01/2007*
N385	**Notification of admission was not timely according to published plan procedures.** *Start: 04/01/2007 | Last Modified: 11/05/2007* *Notes: (Modified 11/5/07)*
N386	**This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage dete as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to reque of the NCD.** *Start: 04/01/2007 | Last Modified: 07/01/2010* *Notes: (Modified 7/1/2010)*
N387	**Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. V forward the claim information.** *Start: 04/01/2007 | Last Modified: 03/01/2009* *Notes: (Modified 3/1/2009)*

N388	**Missing/incomplete/invalid prescription number.** *Start: 08/01/2007 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N389	**Duplicate prescription number submitted.** *Start: 08/01/2007*
N390	**This service/report cannot be billed separately.** *Start: 08/01/2007 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N391	**Missing emergency department records.** *Start: 08/01/2007*
N392	**Incomplete/invalid emergency department records.** *Start: 08/01/2007*
N393	**Missing progress notes/report.** *Start: 08/01/2007 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N394	**Incomplete/invalid progress notes/report.** *Start: 08/01/2007 | Last Modified: 07/01/2008* *Notes: (Modified 7/1/08)*
N395	**Missing laboratory report.** *Start: 08/01/2007*
N396	**Incomplete/invalid laboratory report.** *Start: 08/01/2007*
N397	**Benefits are not available for incomplete service(s)/undelivered item(s).** *Start: 08/01/2007*
N398	**Missing elective consent form.** *Start: 08/01/2007*
N399	**Incomplete/invalid elective consent form.** *Start: 08/01/2007*
N400	**Alert: Electronically enabled providers should submit claims electronically.** *Start: 08/01/2007*

N401	**Missing periodontal charting.** *Start: 08/01/2007*
N402	**Incomplete/invalid periodontal charting.** *Start: 08/01/2007*
N403	**Missing facility certification.** *Start: 08/01/2007*
N404	**Incomplete/invalid facility certification.** *Start: 08/01/2007*
N405	**This service is only covered when the donor's insurer(s) do not provide coverage for the service.** *Start: 08/01/2007*
N406	**This service is only covered when the recipient's insurer(s) do not provide coverage for the service.** *Start: 08/01/2007*
N407	**You are not an approved submitter for this transmission format.** *Start: 08/01/2007*
N408	**This payer does not cover deductibles assessed by a previous payer.** *Start: 08/01/2007*
N409	**This service is related to an accidental injury and is not covered unless provided within a specific time fr the date of the accident.** *Start: 08/01/2007*
N410	**Not covered unless the prescription changes.** *Start: 08/01/2007 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N411	**This service is allowed one time in a 6-month period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N412	**This service is allowed 2 times in a 12-month period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N413	**This service is allowed 2 times in a benefit year.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*

N414	**This service is allowed 4 times in a 12-month period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N415	**This service is allowed 1 time in an 18-month period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N416	**This service is allowed 1 time in a 3-year period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N417	**This service is allowed 1 time in a 5-year period.** *Start: 08/01/2007 | Last Modified: 07/01/2016* *Notes: (Modified 2/1/2009, Reactivated 7/1/2016)*
N418	**Misrouted claim. See the payer's claim submission instructions.** *Start: 08/01/2007*
N419	**Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.** *Start: 08/01/2007*
N420	**Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or T Liability Recovery.** *Start: 08/01/2007*
N421	**Claim payment was the result of a payer's retroactive adjustment due to a review organization decision** *Start: 08/01/2007 | Last Modified: 05/08/2008* *Notes: (Modified 2/29/08, typo fixed 5/8/08)*
N422	**Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive pr** *Start: 08/01/2007 | Last Modified: 05/08/2008* *Notes: (Typo fixed 5/8/08)*
N423	**Claim payment was the result of a payer's retroactive adjustment due to a non standard program.** *Start: 08/01/2007*
N424	**Patient does not reside in the geographic area required for this type of payment.** *Start: 08/01/2007*
N425	**Statutorily excluded service(s).** *Start: 08/01/2007*

N426	**No coverage when self-administered.** *Start: 08/01/2007*
N427	**Payment for eyeglasses or contact lenses can be made only after cataract surgery.** *Start: 08/01/2007*
N428	**Not covered when performed in this place of service.** *Start: 08/01/2007 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N429	**Not covered when considered routine.** *Start: 08/01/2007 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N430	**Procedure code is inconsistent with the units billed.** *Start: 11/05/2007*
N431	**Not covered with this procedure.** *Start: 11/05/2007 | Last Modified: 03/08/2011* *Notes: (Modified 3/8/11)*
N432	**Alert: Adjustment based on a Recovery Audit.** *Start: 11/05/2007 | Last Modified: 07/01/2015* *Notes: (Modified 7/1/15)*
N433	**Resubmit this claim using only your National Provider Identifier (NPI).** *Start: 02/29/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N434	**Missing/Incomplete/Invalid Present on Admission indicator.** *Start: 07/01/2008*
N435	**Exceeds number/frequency approved /allowed within time period without support documentation.** *Start: 07/01/2008*
N436	**The injury claim has not been accepted and a mandatory medical reimbursement has been made.** *Start: 07/01/2008*
N437	**Alert: If the injury claim is accepted, these charges will be reconsidered.** *Start: 07/01/2008*
N438	**This jurisdiction only accepts paper claims.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*

N439	**Missing anesthesia physical status report/indicators.** *Start: 07/01/2008*
N440	**Incomplete/invalid anesthesia physical status report/indicators.** *Start: 07/01/2008*
N441	**This missed/cancelled appointment is not covered.** *Start: 07/01/2008 | Last Modified: 07/15/2013* *Notes: (Modified 7/15/2013)*
N442	**Payment based on an alternate fee schedule.** *Start: 07/01/2008*
N443	**Missing/incomplete/invalid total time or begin/end time.** *Start: 07/01/2008*
N444	**Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Com** *Start: 07/01/2008*
N445	**Missing document for actual cost or paid amount.** *Start: 07/01/2008*
N446	**Incomplete/invalid document for actual cost or paid amount.** *Start: 07/01/2008*
N447	**Payment is based on a generic equivalent as required documentation was not provided.** *Start: 07/01/2008*
N448	**This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N449	**Payment based on a comparable drug/service/supply.** *Start: 07/01/2008*
N450	**Covered only when performed by the primary treating physician or the designee.** *Start: 07/01/2008*
N451	**Missing Admission Summary Report.** *Start: 07/01/2008*
N452	**Incomplete/invalid Admission Summary Report.** *Start: 07/01/2008*

N453	**Missing Consultation Report.** *Start: 07/01/2008*
N454	**Incomplete/invalid Consultation Report.** *Start: 07/01/2008*
N455	**Missing Physician Order.** *Start: 07/01/2008*
N456	**Incomplete/invalid Physician Order.** *Start: 07/01/2008*
N457	**Missing Diagnostic Report.** *Start: 07/01/2008*
N458	**Incomplete/invalid Diagnostic Report.** *Start: 07/01/2008*
N459	**Missing Discharge Summary.** *Start: 07/01/2008*
N460	**Incomplete/invalid Discharge Summary.** *Start: 07/01/2008*
N461	**Missing Nursing Notes.** *Start: 07/01/2008*
N462	**Incomplete/invalid Nursing Notes.** *Start: 07/01/2008*
N463	**Missing support data for claim.** *Start: 07/01/2008*
N464	**Incomplete/invalid support data for claim.** *Start: 07/01/2008*
N465	**Missing Physical Therapy Notes/Report.** *Start: 07/01/2008*
N466	**Incomplete/invalid Physical Therapy Notes/Report.** *Start: 07/01/2008*

N467	**Missing Tests and Analysis Report.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N468	**Incomplete/invalid Report of Tests and Analysis Report.** *Start: 07/01/2008*
N469	**Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Impro and Modernization Act of 2003 (MMA).** *Start: 07/01/2008*
N470	**This payment will complete the mandatory medical reimbursement limit.** *Start: 07/01/2008*
N471	**Missing/incomplete/invalid HIPPS Rate Code.** *Start: 07/01/2008*
N472	**Payment for this service has been issued to another provider.** *Start: 07/01/2008*
N473	**Missing certification.** *Start: 07/01/2008*
N474	**Incomplete/invalid certification.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N475	**Missing completed referral form.** *Start: 07/01/2008*
N476	**Incomplete/invalid completed referral form.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N477	**Missing Dental Models.** *Start: 07/01/2008*
N478	**Incomplete/invalid Dental Models.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N479	**Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).** *Start: 07/01/2008*

N480	**Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).** *Start: 07/01/2008*
N481	**Missing Models.** *Start: 07/01/2008*
N482	**Incomplete/invalid Models.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N485	**Missing Physical Therapy Certification.** *Start: 07/01/2008*
N486	**Incomplete/invalid Physical Therapy Certification.** *Start: 07/01/2008*
N487	**Missing Prosthetics or Orthotics Certification.** *Start: 07/01/2008*
N488	**Incomplete/invalid Prosthetics or Orthotics Certification.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N489	**Missing referral form.** *Start: 07/01/2008*
N490	**Incomplete/invalid referral form.** *Start: 07/01/2008 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N491	**Missing/Incomplete/Invalid Exclusionary Rider Condition.** *Start: 07/01/2008*
N492	**Alert: A network provider may bill the member for this service if the member requested the service and writing, prior to receiving the service, to be financially responsible for the billed charge.** *Start: 07/01/2008*
N493	**Missing Doctor First Report of Injury.** *Start: 07/01/2008*
N494	**Incomplete/invalid Doctor First Report of Injury.** *Start: 07/01/2008*

N495	**Missing Supplemental Medical Report.** *Start: 07/01/2008*
N496	**Incomplete/invalid Supplemental Medical Report.** *Start: 07/01/2008*
N497	**Missing Medical Permanent Impairment or Disability Report.** *Start: 07/01/2008*
N498	**Incomplete/invalid Medical Permanent Impairment or Disability Report.** *Start: 07/01/2008*
N499	**Missing Medical Legal Report.** *Start: 07/01/2008*
N500	**Incomplete/invalid Medical Legal Report.** *Start: 07/01/2008*
N501	**Missing Vocational Report.** *Start: 07/01/2008*
N502	**Incomplete/invalid Vocational Report.** *Start: 07/01/2008*
N503	**Missing Work Status Report.** *Start: 07/01/2008*
N504	**Incomplete/invalid Work Status Report.** *Start: 07/01/2008*
N505	**Alert: This response includes only services that could be estimated in real-time. No estimate will be pro the services that could not be estimated in real-time.** *Start: 11/01/2008 | Last Modified: 03/01/2017* *Notes: (Modified 3/1/2017)*
N506	**Alert: This is an estimate of the member's liability based on the information available at the time the es processed. Actual coverage and member liability amounts will be determined when the claim is process not a pre-authorization or a guarantee of payment.** *Start: 11/01/2008*
N507	**Plan distance requirements have not been met.** *Start: 11/01/2008*
N508	**Alert: This real-time claim adjudication response represents the member responsibility to the provider reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the i**

	there are any questions. *Start: 11/01/2008 | Last Modified: 03/01/2017* *Notes: (Modified 3/1/2017)*
N509	**Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to c member liability for this claim/service. Actual payment from the Consumer Spending Account will depe availability of funds and determination of eligible services at the time of payment processing.** *Start: 11/01/2008*
N510	**Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient fu cover the member's liability for this claim/service. Actual payment from the Consumer Spending Accou depend on the availability of funds and determination of eligible services at the time of payment proce** *Start: 11/01/2008*
N511	**Alert: Information on the availability of Consumer Spending Account funds to cover the member liabilit claim/service is not available at this time.** *Start: 11/01/2008*
N512	**Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to th adjudication.** *Start: 11/01/2008*
N513	**Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.** *Start: 11/01/2008*
N516	**Records indicate a mismatch between the submitted NPI and EIN.** *Start: 03/01/2009*
N517	**Resubmit a new claim with the requested information.** *Start: 03/01/2009*
N518	**No separate payment for accessories when furnished for use with oxygen equipment.** *Start: 03/01/2009*
N519	**Invalid combination of HCPCS modifiers.** *Start: 07/01/2009*
N520	**Alert: Payment made from a Consumer Spending Account.** *Start: 07/01/2009*
N521	**Mismatch between the submitted provider information and the provider information stored in our syst** *Start: 11/01/2009*

N522	**Duplicate of a claim processed, or to be processed, as a crossover claim.** *Start: 11/01/2009 | Last Modified: 03/01/2010*
N523	**The limitation on outlier payments defined by this payer for this service period has been met. The outli otherwise applicable to this claim has not been paid.** *Start: 03/01/2010*
N524	**Based on policy this payment constitutes payment in full.** *Start: 03/01/2010*
N525	**These services are not covered when performed within the global period of another service.** *Start: 03/01/2010*
N526	**Not qualified for recovery based on employer size.** *Start: 03/01/2010*
N527	**We processed this claim as the primary payer prior to receiving the recovery demand.** *Start: 03/01/2010*
N528	**Patient is entitled to benefits for Institutional Services only.** *Start: 03/01/2010 | Last Modified: 07/01/2010* *Notes: (Modified 7/1/10)*
N529	**Patient is entitled to benefits for Professional Services only.** *Start: 03/01/2010 | Last Modified: 07/01/2010* *Notes: (Modified 7/1/10)*
N530	**Not Qualified for Recovery based on enrollment information.** *Start: 03/01/2010 | Last Modified: 07/01/2010* *Notes: (Modified 7/1/10)*
N531	**Not qualified for recovery based on direct payment of premium.** *Start: 03/01/2010*
N532	**Not qualified for recovery based on disability and working status.** *Start: 03/01/2010*
N533	**Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.** *Start: 07/01/2010*
N534	**This is an individual policy, the employer does not participate in plan sponsorship.** *Start: 07/01/2010*

N535	**Payment is adjusted when procedure is performed in this place of service based on the submitted proce and place of service.** *Start: 07/01/2010*
N536	**We are not changing the prior payer's determination of patient responsibility, which you may collect, as service is not covered by us.** *Start: 07/01/2010*
N537	**We have examined claims history and no records of the services have been found.** *Start: 07/01/2010*
N538	**A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to i patients/residents.** *Start: 07/01/2010*
N539	**Alert: We processed appeals/waiver requests on your behalf and that request has been denied.** *Start: 07/01/2010*
N540	**Payment adjusted based on the interrupted stay policy.** *Start: 11/01/2010*
N541	**Mismatch between the submitted insurance type code and the information stored in our system.** *Start: 11/01/2010*
N542	**Missing income verification.** *Start: 03/08/2011*
N543	**Incomplete/invalid income verification.** *Start: 03/08/2011 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N544	**Alert: Although this was paid, you have billed with a referring/ordering provider that does not match ou record. Unless corrected this will not be paid in the future.** *Start: 07/01/2011 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N545	**Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Inc Program.** *Start: 07/01/2011*
N546	**Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.** *Start: 07/01/2011*

N547	**A refund request (Frequency Type Code 8) was processed previously.** *Start: 03/06/2012*
N548	**Alert: Patient's calendar year deductible has been met.** *Start: 03/06/2012*
N549	**Alert: Patient's calendar year out-of-pocket maximum has been met.** *Start: 03/06/2012*
N550	**Alert: You have not responded to requests to revalidate your provider/supplier enrollment information failure to revalidate your enrollment information will result in a payment hold in the near future.** *Start: 03/06/2012*
N551	**Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.** *Start: 03/06/2012*
N552	**Payment adjusted to reverse a previous withhold/bonus amount.** *Start: 03/06/2012*
N554	**Missing/Incomplete/Invalid Family Planning Indicator.** *Start: 07/01/2012 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N555	**Missing medication list.** *Start: 07/01/2012*
N556	**Incomplete/invalid medication list.** *Start: 07/01/2012*
N557	**This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in w service area the specimen was collected.** *Start: 07/01/2012*
N558	**This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in w service area the equipment was received.** *Start: 07/01/2012*
N559	**This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in w service area the Ordering Physician is located.** *Start: 07/01/2012*
N560	**The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim v received.** *Start: 11/01/2012*

N561	**The bundled claim originally submitted for this episode of care includes related readmissions. You may the original claim to receive a corrected payment based on this readmission.** *Start: 11/01/2012*
N562	**The provider number of your incoming claim does not match the provider number on the processed No Admission (NOA) for this bundled payment.** *Start: 11/01/2012*
N563	**Alert: Missing required provider/supplier issuance of advance patient notice of non-coverage. The patie liable for payment for this service.** *Start: 11/01/2012 | Last Modified: 11/01/2015* *Notes: Related to M39 (Modified 11/1/2015)*
N564	**Patient did not meet the inclusion criteria for the demonstration project or pilot program.** *Start: 11/01/2012*
N565	**Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable re code must include an appropriate modifier for the claim to be processed.** *Start: 11/01/2012 | Last Modified: 03/01/2013* *Notes: (Modified 3/1/13)*
N566	**Alert: This procedure code requires functional reporting. Future claims containing this procedure code include an applicable non-payable code and appropriate modifiers for the claim to be processed.** *Start: 11/01/2012*
N567	**Not covered when considered preventative.** *Start: 03/01/2013*
N568	**Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV in** *Start: 03/01/2013*
N569	**Not covered when performed for the reported diagnosis.** *Start: 03/01/2013*
N570	**Missing/incomplete/invalid credentialing data.** *Start: 03/01/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N571	**Alert: Payment will be issued quarterly by another payer/contractor.** *Start: 03/01/2013*
N572	**This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers submitted.** *Start: 03/01/2013 | Last Modified: 07/01/2014*

N573	**Alert: You have been overpaid and must refund the overpayment. The refund will be requested separat another payer/contractor.** *Start: 03/01/2013*
N574	**Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Pl that the claim ordering/referring provider information is accurate or contact the ordering/referring pro** *Start: 07/15/2013*
N575	**Mismatch between the submitted ordering/referring provider name and the ordering/referring provide stored in our records.** *Start: 07/15/2013*
N576	**Services not related to the specific incident/claim/accident/loss being reported.** *Start: 07/15/2013*
N577	**Personal Injury Protection (PIP) Coverage.** *Start: 07/15/2013*
N578	**Coverages do not apply to this loss.** *Start: 07/15/2013*
N579	**Medical Payments Coverage (MPC).** *Start: 07/15/2013*
N580	**Determination based on the provisions of the insurance policy.** *Start: 07/15/2013*
N581	**Investigation of coverage eligibility is pending.** *Start: 07/15/2013*
N582	**Benefits suspended pending the patient's cooperation.** *Start: 07/15/2013*
N583	**Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.** *Start: 07/15/2013*
N584	**Not covered based on the insured's noncompliance with policy or statutory conditions.** *Start: 07/15/2013*
N585	**Benefits are no longer available based on a final injury settlement.** *Start: 07/15/2013*
N586	**The injured party does not qualify for benefits.** *Start: 07/15/2013*

N587	**Policy benefits have been exhausted.** *Start: 07/15/2013*
N588	**The patient has instructed that medical claims/bills are not to be paid.** *Start: 07/15/2013*
N589	**Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicat condition or while the ability to operate such a vehicle is impaired by the use of a drug.** *Start: 07/15/2013*
N590	**Missing independent medical exam detailing the cause of injuries sustained and medical necessity of se rendered.** *Start: 07/15/2013*
N591	**Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).** *Start: 07/15/2013*
N592	**Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescr** *Start: 07/15/2013*
N593	**Not covered based on failure to attend a scheduled Independent Medical Exam (IME).** *Start: 07/15/2013*
N594	**Records reflect the injured party did not complete an Application for Benefits for this loss.** *Start: 07/15/2013*
N595	**Records reflect the injured party did not complete an Assignment of Benefits for this loss.** *Start: 07/15/2013*
N596	**Records reflect the injured party did not complete a Medical Authorization for this loss.** *Start: 07/15/2013*
N597	**Adjusted based on a medical/dental provider's apportionment of care between related injuries and oth unrelated medical/dental conditions/injuries.** *Start: 07/15/2013 | Last Modified: 11/01/2013*
N598	**Health care policy coverage is primary.** *Start: 07/15/2013*
N599	**Our payment for this service is based upon a reasonable amount pursuant to both the terms and condi policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, permits, when determining a reasonable charge for a service, an insurer to consider usual and customa and payments accepted by the provider, reimbursement levels in the community and various federal ar schedules applicable to automobile and other insurance coverages, and other information relevant to t reasonableness of the reimbursement for the service. The payment for this service is based upon 200%**

	Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered. *Start: 07/15/2013*
N600	**Adjusted based on the applicable fee schedule for the region in which the service was rendered.** *Start: 07/15/2013*
N601	**In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payn recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.** *Start: 07/15/2013*
N602	**Adjusted based on the Redbook maximum allowance.** *Start: 07/15/2013*
N603	**This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury and Motor Bus Medical Expense Insurance Coverage.** *Start: 07/15/2013*
N604	**In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix NYCRR.** *Start: 07/15/2013*
N605	**This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), to Regulation 68.** *Start: 07/15/2013*
N606	**The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule 009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.** *Start: 07/15/2013*
N607	**Service provided for non-compensable condition(s).** *Start: 07/15/2013*
N608	**The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, sp type of service. This fee is calculated in compliance with Act 6.** *Start: 07/15/2013*
N609	**80% of the provider's billed amount is being recommended for payment according to Act 6.** *Start: 07/15/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N610	**Alert: Payment based on an appropriate level of care.** *Start: 07/15/2013*

N611	**Claim in litigation. Contact insurer for more information.** *Start: 07/15/2013*
N612	**Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.** *Start: 07/15/2013*
N613	**Alert: Although this was paid, you have billed with an ordering provider that needs to update their enro record. Please verify that the ordering provider information you submitted on the claim is accurate and contact the ordering provider instructing them to update their enrollment record. Unless corrected, a cl this ordering provider will not be paid in the future.** *Start: 07/15/2013*
N614	**Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Payment Information).** *Start: 07/15/2013*
N615	**Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of thre consecutive months for non-payment of premium. Under 45 CFR 156.270, a Qualified Health Plan issue all appropriate claims for services rendered to the enrollee during the first month of the grace period a pend claims for services rendered to the enrollee in the second and third months of the grace period.** *Start: 07/15/2013 | Last Modified: 03/01/2017* *Notes: (Modified 3/1/2017)*
N616	**Alert: This enrollee is in the first month of the advance premium tax credit grace period.** *Start: 07/15/2013*
N617	**This enrollee is in the second or third month of the advance premium tax credit grace period.** *Start: 07/15/2013*
N618	**Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.** *Start: 07/15/2013*
N619	**Coverage terminated for non-payment of premium.** *Start: 07/15/2013*
N620	**Alert: This procedure code is for quality reporting/informational purposes only.** *Start: 07/15/2013*
N621	**Charges for Jurisdiction required forms, reports, or chart notes are not payable.** *Start: 07/15/2013*
N622	**Not covered based on the date of injury/accident.** *Start: 07/15/2013*

N623	**Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.** *Start: 07/15/2013*
N624	**The associated Workers' Compensation claim has been withdrawn.** *Start: 07/15/2013*
N625	**Missing/Incomplete/Invalid Workers' Compensation Claim Number.** *Start: 07/15/2013*
N626	**New or established patient E/M codes are not payable with chiropractic care codes.** *Start: 07/15/2013*
N628	**Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.** *Start: 07/15/2013*
N629	**Reviews/documentation/notes/summaries/reports/charts not requested.** *Start: 07/15/2013*
N630	**Referral not authorized by attending physician.** *Start: 07/15/2013*
N631	**Medical Fee Schedule does not list this code. An allowance was made for a comparable service.** *Start: 07/15/2013*
N633	**Additional anesthesia time units are not allowed.** *Start: 07/15/2013*
N634	**The allowance is calculated based on anesthesia time units.** *Start: 07/15/2013*
N635	**The Allowance is calculated based on the anesthesia base units plus time.** *Start: 07/15/2013*
N636	**Adjusted because this is reimbursable only once per injury.** *Start: 07/15/2013*
N637	**Consultations are not allowed once treatment has been rendered by the same provider.** *Start: 07/15/2013*
N638	**Reimbursement has been made according to the home health fee schedule.** *Start: 07/15/2013*
N639	**Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.** *Start: 07/15/2013*

N640	**Exceeds number/frequency approved/allowed within time period.** *Start: 07/15/2013*
N641	**Reimbursement has been based on the number of body areas rated.** *Start: 07/15/2013*
N642	**Adjusted when billed as individual tests instead of as a panel.** *Start: 07/15/2013*
N643	**The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedul** *Start: 07/15/2013*
N644	**Reimbursement has been made according to the bilateral procedure rule.** *Start: 07/15/2013*
N645	**Mark-up allowance.** *Start: 07/15/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N646	**Reimbursement has been adjusted based on the guidelines for an assistant.** *Start: 07/15/2013*
N647	**Adjusted based on diagnosis-related group (DRG).** *Start: 07/15/2013*
N648	**Adjusted based on Stop Loss.** *Start: 07/15/2013*
N649	**Payment based on invoice.** *Start: 07/15/2013*
N650	**This policy was not in effect for this date of loss. No coverage is available.** *Start: 07/15/2013*
N651	**No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.** *Start: 07/15/2013*
N652	**The date of service is before the date of loss.** *Start: 07/15/2013*
N653	**The date of injury does not match the reported date of loss.** *Start: 07/15/2013*

N654	**Adjusted based on achievement of maximum medical improvement (MMI).** *Start: 07/15/2013*
N655	**Payment based on provider's geographic region.** *Start: 07/15/2013*
N656	**An interest payment is being made because benefits are being paid outside the statutory requirement.** *Start: 07/15/2013*
N657	**This should be billed with the appropriate code for these services.** *Start: 07/15/2013*
N658	**The billed service(s) are not considered medical expenses.** *Start: 07/15/2013*
N659	**This item is exempt from sales tax.** *Start: 07/15/2013*
N660	**Sales tax has been included in the reimbursement.** *Start: 07/15/2013*
N661	**Documentation does not support that the services rendered were medically necessary.** *Start: 07/15/2013*
N662	**Alert: Consideration of payment will be made upon receipt of a final bill.** *Start: 07/15/2013*
N663	**Adjusted based on an agreed amount.** *Start: 07/15/2013*
N664	**Adjusted based on a legal settlement.** *Start: 07/15/2013*
N665	**Services by an unlicensed provider are not reimbursable.** *Start: 07/15/2013*
N666	**Only one evaluation and management code at this service level is covered during the course of care.** *Start: 07/15/2013*
N667	**Missing prescription.** *Start: 07/15/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*

N668	**Incomplete/invalid prescription.** *Start: 07/15/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N669	**Adjusted based on the Medicare fee schedule.** *Start: 07/15/2013*
N670	**This service code has been identified as the primary procedure code subject to the Medicare Multiple P Payment Reduction (MPPR) rule.** *Start: 07/15/2013*
N671	**Payment based on a jurisdiction cost-charge ratio.** *Start: 07/15/2013*
N672	**Alert: Amount applied to Health Insurance Offset.** *Start: 07/15/2013*
N673	**Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fe amount.** *Start: 07/15/2013*
N674	**Not covered unless a pre-requisite procedure/service has been provided.** *Start: 07/15/2013*
N675	**Additional information is required from the injured party.** *Start: 07/15/2013*
N676	**Service does not qualify for payment under the Outpatient Facility Fee Schedule.** *Start: 07/15/2013*
N677	**Alert: Films/Images will not be returned.** *Start: 11/01/2013*
N678	**Missing post-operative images/visual field results.** *Start: 11/01/2013*
N679	**Incomplete/Invalid post-operative images/visual field results.** *Start: 11/01/2013*
N680	**Missing/Incomplete/Invalid date of previous dental extractions.** *Start: 11/01/2013*
N681	**Missing/Incomplete/Invalid full arch series.** *Start: 11/01/2013*

N682	**Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.** *Start: 11/01/2013*
N683	**Missing/Incomplete/Invalid prior treatment documentation.** *Start: 11/01/2013*
N684	**Payment denied as this is a specialty claim submitted as a general claim.** *Start: 11/01/2013*
N685	**Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.** *Start: 11/01/2013*
N686	**Missing/incomplete/Invalid questionnaire needed to complete payment determination.** *Start: 11/01/2013*
N687	**Alert: This reversal is due to a retroactive disenrollment.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N688	**Alert: This reversal is due to a medical or utilization review decision.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N689	**Alert: This reversal is due to a retroactive rate change.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N690	**Alert: This reversal is due to a provider submitted appeal.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N691	**Alert: This reversal is due to a patient submitted appeal.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N692	**Alert: This reversal is due to an incorrect rate on the initial adjudication.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N693	**Alert: This reversal is due to a cancellation of the claim by the provider.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*

N694	**Alert: This reversal is due to a resubmission/change to the claim by the provider.** *Start: 11/01/2013*
N695	**Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudica** *Start: 11/01/2013*
N696	**Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adju** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N697	**Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.** *Start: 11/01/2013 | Last Modified: 03/14/2014* *Notes: To be used with claim/service reversal. (Modified 3/14/2014)*
N698	**Alert: This reversal is due to non-payment of the health insurance premiums (Health Insurance Exchang by the end of the premium payment grace period, resulting in loss of coverage.** *Start: 11/01/2013 | Last Modified: 11/01/2015* *Notes: To be used with claim/service reversal. (Modified 3/14/2014, 11/1/2015)*
N699	**Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.** *Start: 03/01/2014*
N700	**Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.** *Start: 03/01/2014*
N701	**Payment adjusted based on the Value-based Payment Modifier.** *Start: 03/01/2014*
N702	**Decision based on review of previously adjudicated claims or for claims in process for the same/similar services.** *Start: 03/01/2014*
N703	**This service is incompatible with previously adjudicated claims or claims in process.** *Start: 03/01/2014*
N704	**Alert: You may not appeal this decision but can resubmit this claim/service with corrected information warranted.** *Start: 03/01/2014 | Last Modified: 03/14/2014* *Notes: (Modified 3/14/2014)*
N705	**Incomplete/invalid documentation.** *Start: 03/01/2014*

N706	**Missing documentation.** *Start: 03/01/2014*
N707	**Incomplete/invalid orders.** *Start: 03/01/2014*
N708	**Missing orders.** *Start: 03/01/2014*
N709	**Incomplete/invalid notes.** *Start: 03/01/2014*
N710	**Missing notes.** *Start: 03/01/2014*
N711	**Incomplete/invalid summary.** *Start: 03/01/2014*
N712	**Missing summary.** *Start: 03/01/2014*
N713	**Incomplete/invalid report.** *Start: 03/01/2014*
N714	**Missing report.** *Start: 03/01/2014*
N715	**Incomplete/invalid chart.** *Start: 03/01/2014*
N716	**Missing chart.** *Start: 03/01/2014*
N717	**Incomplete/Invalid documentation of face-to-face examination.** *Start: 03/01/2014*
N718	**Missing documentation of face-to-face examination.** *Start: 03/01/2014*
N719	**Penalty applied based on plan requirements not being met.** *Start: 03/01/2014*

N720	**Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between patient's payment and the amount shown as patient responsibility on this notice.** *Start: 03/01/2014*
N721	**This service is only covered when performed as part of a clinical trial.** *Start: 03/01/2014*
N722	**Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item** *Start: 03/01/2014*
N723	**Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.** *Start: 03/01/2014*
N724	**Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.** *Start: 03/01/2014*
N725	**A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnos** *Start: 03/01/2014*
N726	**A conditional payment is not allowed.** *Start: 03/01/2014*
N727	**A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagno** *Start: 03/01/2014*
N728	**A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM diagnosis.** *Start: 03/01/2014*
N729	**Missing patient medical/dental record for this service.** *Start: 11/01/2014*
N730	**Incomplete/invalid patient medical/dental record for this service.** *Start: 11/01/2014*
N731	**Incomplete/Invalid mental health assessment.** *Start: 11/01/2014*
N732	**Services performed at an unlicensed facility are not reimbursable.** *Start: 11/01/2014*
N733	**Regulatory surcharges are paid directly to the state.** *Start: 11/01/2014*

N734	**The patient is eligible for these medical services only when unable to work or perform normal activities illness or injury.** *Start: 11/01/2014*
N736	**Incomplete/invalid Sleep Study Report.** *Start: 03/01/2015*
N737	**Missing Sleep Study Report.** *Start: 03/01/2015*
N738	**Incomplete/invalid Vein Study Report.** *Start: 03/01/2015*
N739	**Missing Vein Study Report.** *Start: 03/01/2015*
N740	**The member's Consumer Spending Account does not contain sufficient funds to cover the member's lia this claim/service.** *Start: 03/01/2015*
N741	**This is a site neutral payment.** *Start: 03/01/2015*
N743	**Adjusted because the services may be related to an employment accident.** *Start: 03/01/2015*
N744	**Adjusted because the services may be related to an auto/other accident.** *Start: 03/01/2015 | Last Modified: 03/01/2017* *Notes: (Modified 3/1/2017)*
N745	**Missing Ambulance Report.** *Start: 03/01/2015*
N746	**Incomplete/invalid Ambulance Report.** *Start: 03/01/2015*
N747	**This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.** *Start: 03/01/2015*
N748	**Adjusted because the related hospital charges have not been received.** *Start: 03/01/2015*
N749	**Missing Blood Gas Report.** *Start: 03/01/2015*

N750	**Incomplete/invalid Blood Gas Report.** *Start: 03/01/2015*
N751	**Adjusted because the patient is covered under a Medicare Part D plan.** *Start: 03/01/2015 | Last Modified: 07/01/2017* *Notes: (Modified 7/1/2017)*
N752	**Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).** *Start: 03/01/2015*
N753	**Missing/incomplete/invalid Attachment Control Number.** *Start: 07/01/2015*
N754	**Missing/incomplete/invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.** *Start: 07/01/2015*
N755	**Missing/incomplete/invalid ICD Indicator.** *Start: 07/01/2015 | Last Modified: 03/01/2016* *Notes: (Modified 3/1/2016)*
N756	**Missing/incomplete/invalid point of drop-off address.** *Start: 07/01/2015*
N757	**Adjusted based on the Federal Indian Fees schedule (MLR).** *Start: 07/01/2015*
N758	**Adjusted based on the prior authorization decision.** *Start: 07/01/2015*
N759	**Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-** *Start: 07/01/2015*
N760	**This facility is not authorized to receive payment for the service(s).** *Start: 11/01/2015*
N761	**This provider is not authorized to receive payment for the service(s).** *Start: 11/01/2015*
N762	**This facility is not certified for Tomosynthesis (3-D) mammography.** *Start: 11/01/2015*
N763	**The demonstration code is not appropriate for this claim; resubmit without a demonstration code.** *Start: 11/01/2015*

N764	**Missing/incomplete/invalid Hematocrit (HCT) value.** *Start: 03/01/2016*
N765	**This payer does not cover coinsurance assessed by a previous payer.** *Start: 03/01/2016 | Last Modified: 03/01/2018* *Notes: (Modified 3/1/2018)*
N766	**This payer does not cover co-payment assessed by a previous payer.** *Start: 03/01/2016*
N767	**The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to a benefits being processed.** *Start: 03/01/2016*
N768	**Incomplete/invalid initial evaluation report.** *Start: 03/01/2016*
N769	**A lateral diagnosis is required.** *Start: 03/01/2016*
N770	**The adjustment request received from the provider has been processed. Your original claim has been a based on the information received.** *Start: 03/01/2016*
N771	**Alert: Under Federal law you cannot charge more than the limiting charge amount.** *Start: 07/01/2016*
N772	**Alert: Rebill urgent/emergent and ancillary services separately.** *Start: 07/01/2016*
N773	**Drug supplied not obtained from specialty vendor.** *Start: 07/01/2016*
N774	**Alert: Refer to your Third Party Processor Agreement for specific information on fees associated with th type.** *Start: 07/01/2016*
N775	**Payment adjusted based on x-ray radiograph on film.** *Start: 11/01/2016*
N776	**This service is not a covered Telehealth service.** *Start: 11/01/2016*

N777	**Missing Assignment of Benefits Indicator.** *Start: 11/01/2016 | Last Modified: 03/01/2017* *Notes: (Modified 3/1/2017)*
N778	**Missing Primary Care Physician Information.** *Start: 11/01/2016*
N779	**Replacement/Void claims cannot be submitted until the original claim has finalized. Please resubmit on payment or denial is received.** *Start: 11/01/2016*
N780	**Missing/incomplete/invalid end therapy date.** *Start: 11/01/2016*
N781	**Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully col deductible. This amount may be billed to a subsequent payer.** *Start: 11/01/2016 | Last Modified: 03/01/2018* *Notes: (Modified 3/1/2018)*
N782	**Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully col coinsurance. This amount may be billed to a subsequent payer.** *Start: 11/01/2016 | Last Modified: 03/01/2018* *Notes: (Modified 3/1/2018)*
N783	**Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully col copayment. This amount may be billed to a subsequent payer.** *Start: 11/01/2016 | Last Modified: 03/01/2018* *Notes: (Modified 3/1/2018)*
N784	**Missing comprehensive procedure code.** *Start: 11/01/2016*
N785	**Missing current radiology film/images.** *Start: 11/01/2016*
N786	**Benefit limitation for the orthodontic active and/or retention phase of treatment.** *Start: 11/01/2016*
N787	**Alert: Under 42 CFR 410.43, an eligible Partial Hospitalization Program (PHP) patient/beneficiary requir minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be in accordance with the plan of care.** *Start: 03/01/2017*

N788	**Alert: The third-party administrator/review organization did not receive the required information.** *Start: 03/01/2017 | Last Modified: 07/01/2018* *Notes: (Modified 11/1/2017, 7/1/2018)*
N789	**Clinical Trial is not a covered benefit.** *Start: 07/01/2017*
N790	**Provider/supplier not accredited for product/service.** *Start: 07/01/2017*
N791	**Missing history & physical report.** *Start: 07/01/2017*
N792	**Incomplete/invalid history & physical report.** *Start: 07/01/2017*
N794	**Payment adjusted based on type of technology used.** *Start: 07/01/2017*
N795	**Item must be resubmitted as a purchase.** *Start: 11/01/2017*
N796	**Missing/incomplete/invalid Hemoglobin (Hb or Hgb) value.** *Start: 11/01/2017*
N797	**Missing/incomplete/invalid date qualifier.** *Start: 11/01/2017*
N798	**Submit a void request for the original claim and resubmit a new claim.** *Start: 11/01/2017*
N799	**Submitted identifier must be an individual identifier, not group identifier.** *Start: 11/01/2017 | Last Modified: 03/01/2018* *Notes: (Modified 3/1/2018)*
N800	**Only one service date is allowed per claim.** *Start: 03/01/2018*
N801	**Services performed in a Medicare participating or CAH facility under a self-insured tribal Group Health P accordance with Federal Regulation 42 CFR 136.** *Start: 03/01/2018*

N802	**This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in w** **service area the Rendering Physician is located.** *Start: 03/01/2018*
N803	**Submission of the claim for the service rendered is the responsibility of the Contracted Medical Group** *Start: 03/01/2018*
N804	**Alert: The claim/service was processed through the Outpatient Code Editor (OCE).** *Start: 07/01/2018*
N805	**Alert: The claim/service was processed through the Correct Code Editor (CCE).** *Start: 07/01/2018*
N806	**Payment is included in the Global transplant allowance.** *Start: 07/01/2018*
N807	**Payment adjustment based on the Merit-based Incentive Payment System (MIPS).** *Start: 07/01/2018*
N808	**Not covered for this provider type / provider specialty.** *Start: 07/01/2018*
N809	**Alert: The fee schedule amount for this service was adjusted based on prior competitive bidding rates.** **information, contact your local contractor.** *Start: 11/01/2018*
N810	**Alert: Due to federal, state or local disaster declaration, this claim has been processed at the in-networ** **benefit. At the conclusion or expiration of the disaster declaration, network payment rules will be reins** *Start: 11/01/2018 | Last Modified: 03/01/2019*
N811	**Missing Federal Sequestration Reduction from Prior Payer.** *Start: 11/01/2018*
N812	**The start service date through end service date cannot span greater than 18 months.** *Start: 11/01/2018*
N815	**Missing/Incomplete/Invalid NDC Unit Count** *Start: 07/01/2019*
N816	**Missing/Incomplete/Invalid NDC Unit of Measure** *Start: 07/01/2019*

N817	**Alert: Applicable laboratories are required to collect and report private payor data and report that data between January 1, 2020 - March 31, 2020.** *Start: 07/01/2019*
N818	**Claims Dates of Service do not match Electronic Visit Verification System.** *Start: 07/01/2019*
N819	**Patient not enrolled in Electronic Visit Verification System.** *Start: 07/01/2019*
N820	**Electronic Visit Verification System units do not meet requirements of visit.** *Start: 07/01/2019*
N821	**Electronic Visit Verification System visit not found.** *Start: 07/01/2019*
N822	**Missing procedure modifier(s).** *Start: 07/01/2019 | Last Modified: 11/01/2019*
N823	**Incomplete/Invalid procedure modifier(s).** *Start: 07/01/2019 | Last Modified: 11/01/2019*
N824	**Electronic Visit Verification (EVV) data must be submitted through EVV Vendor.** *Start: 11/01/2019*
N825	**Early intervention guidelines were not met.** *Start: 11/01/2019*
N826	**Patient did not meet the inclusion criteria for the Medicare Shared Savings Program.** *Start: 11/01/2019*
N827	**Missing/Incomplete/Invalid Federal Information Processing Standard (FIPS) Code.** *Start: 11/01/2019*
N828	**Alert: Payment is suppressed due to a contracted funding.** *Start: 03/01/2020*
N829	**Missing/incomplete/invalid Diagnostics Exchange Z-Code Identifier.** *Start: 03/01/2020*
N830	**Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ N Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the mem may be considered provider liability or be billable to a subsequent payer. Any amount the provider coll the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(e**

	Start: 03/01/2020 | Last Modified: 03/01/2022 *Notes: (Modified 3/1/2022)*
N831	**You have not responded to requests to revalidate your provider/supplier enrollment information.** *Start: 03/01/2020*
N832	**Duplicate occurrence code/occurrence span code.** *Start: 07/01/2020*
N833	**Patient share of cost waived.** *Start: 07/01/2020*
N834	**Jurisdiction exempt from sales and health tax charges.** *Start: 11/01/2020*
N835	**Unrelated Service/procedure/treatment is reduced. The balance of this charge is the patient's responsi** *Start: 11/01/2020*
N836	**Provider W9 or Payee Registration not on file.** *Start: 11/01/2020*
N837	**Alert: Missing modifier was added.** *Start: 11/01/2020*
N838	**Alert: Service/procedure postponed due to a federal, state, or local mandate/disaster declaration. Any applied to deductible or member liability will be applied to the prior plan year from which the procedu cancelled.** *Start: 11/01/2020*
N839	**The procedure code was added/changed because the level of service exceeds the compensable conditi** *Start: 03/01/2021*
N840	**Worker's compensation claim filed with a different state.** *Start: 03/01/2021*
N841	**Alert: North Dakota Administrative Rule 92-01-02-50.3.** *Start: 03/01/2021*
N842	**Alert: Patient cannot be billed for charges.** *Start: 03/01/2021*
N843	**Missing/incomplete/invalid Core-Based Statistical Area (CBSA) code.** *Start: 03/01/2021*

N844	**This claim, or a portion of this claim, was processed in accordance with the Nebraska Legislative LB997 2020 - Out of Network Emergency Medical Care Act.** *Start: 03/01/2021*
N845	**Alert: Nebraska Legislative LB997 July 24, 2020 - Out of Network Emergency Medical Care Act.** *Start: 03/01/2021*
N846	**National Drug Code (NDC) supplied does not correspond to the HCPCs/CPT billed.** *Start: 03/01/2021*
N847	**National Drug Code (NDC) billed is obsolete.** *Start: 03/01/2021*
N848	**National Drug Code (NDC) billed cannot be associated with a product.** *Start: 03/01/2021*
N849	**Missing Tooth Clause: Tooth missing prior to the member effective date.** *Start: 03/01/2021*
N850	**Missing/incomplete/invalid narrative explaining/describing this service/treatment.** *Start: 03/01/2021*
N851	**Payment reduced because services were furnished by a therapy assistant.** *Start: 07/01/2021*
N852	**The pay-to and rendering provider tax identification numbers (TINs) do not match** *Start: 07/01/2021*
N853	**The number of modalities performed per session exceeds our acceptable maximum.** *Start: 07/01/2021*
N854	**Alert: If you have primary other health insurance (OHI) coverage that has denied services, you must exh appeal levels with your primary OHI before we can consider your claim for reimbursement.** *Start: 07/01/2021*
N855	**This coverage is subject to the exclusive jurisdiction of ERISA (1974), U.S.C. SEC 1001.** *Start: 07/01/2021*
N856	**This coverage is not subject to the exclusive jurisdiction of ERISA (1974), U.S.C. SEC 1001.** *Start: 07/01/2021*
N857	**This claim has been adjusted/reversed. Refund any collected copayment to the member.** *Start: 11/01/2021*

N858	**Alert: State regulations relating to an Out of Network Medical Emergency Care Act were applied to the of this claim. Payment amounts are eligible for dispute following the state's documented appeal/ grieva arbitration process.** *Start: 11/01/2021*
N859	**Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).** *Start: 11/01/2021 | Last Modified: 03/01/2022* *Notes: (modified 3/1/2022)*
N860	**Alert: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the m share(s).** *Start: 11/01/2021*
N861	**Alert: Mismatch between the submitted Patient Liability/Share of Cost and the amount on record for th recipient.** *Start: 03/01/2022*
N862	**Alert: Member cost share is in compliance with the No Surprises Act, and is calculated using the lesser o or billed charge.** *Start: 03/01/2022*
N863	**Alert: This claim is subject to the No Surprises Act (NSA). The amount paid is the final out-of-network ra calculated based on an All Payer Model Agreement, in accordance with the NSA.** *Start: 03/01/2022*
N864	**Alert: This claim is subject to the No Surprises Act provisions that apply to emergency services.** *Start: 03/01/2022*
N865	**Alert: This claim is subject to the No Surprises Act provisions that apply to nonemergency services furni nonparticipating providers during a patient visit to a participating facility.** *Start: 03/01/2022*
N866	**Alert: This claim is subject to the No Surprises Act provisions that apply to services furnished by nonpar providers of air ambulance services.** *Start: 03/01/2022*
N867	**Alert: Cost sharing was calculated based on a specified state law, in accordance with the No Surprises A** *Start: 03/01/2022*
N868	**Alert: Cost sharing was calculated based on an All-Payer Model Agreement, in accordance with the No S Act.** *Start: 03/01/2022*

N869	**Alert: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Act.** *Start: 03/01/2022*
N870	**Alert: In accordance with the No Surprises Act, cost sharing was based on the billed amount because th amount was lower than the qualifying payment amount.** *Start: 03/01/2022*
N871	**Alert: This initial payment was calculated based on a specified state law, in accordance with the No Surp** *Start: 03/01/2022*
N872	**Alert: This final payment was calculated based on a specified state law, in accordance with the No Surpr** *Start: 03/01/2022*
N873	**Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with th Surprises Act.** *Start: 03/01/2022*
N874	**Alert: This final payment was determined through open negotiation, in accordance with the No Surpris** *Start: 03/01/2022*
N875	**Alert: This final payment equals the amount selected as the out-of-network rate by a Federal Independe Resolution Entity, in accordance with the No Surprises Act.** *Start: 03/01/2022*
N876	**Alert: This item or service is covered under the plan. This is a notice of denial of payment provided in ac with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotia out-of-network rate than the amount paid by the patient in cost sharing.** *Start: 03/01/2022*
N877	**Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility m open negotiation if they desire to negotiate a higher out-of-network rate.** *Start: 03/01/2022*
N878	**Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, b and consent was not provided and obtained in a manner consistent with applicable Federal law. Thus, c and the total amount paid have been calculated based on the requirements under the No Surprises Act balance billing is prohibited.** *Start: 03/01/2022*
N879	**Alert: The notice and consent to balance bill, and to be charged out-of-network cost sharing, that was o from the patient with regard to the billed services, is not permitted for these services. Thus, cost sharin total amount paid have been calculated based on the requirements under the No Surprises Act, and bal is prohibited.** *Start: 03/01/2022*

N880	**Original claim closed due to changes in submitted data. Adjustment claim will be processed under a nev number.** *Start: 11/01/2022*
N881	**Client Obligation, patient responsibility for Home & Community Based Services (HCBS)** *Start: 11/01/2022*
N882	**Alert: The out-of-network payment and cost sharing amounts were based on the plan's allowance beca provider or facility obtained the patient's consent to waive the balance billing protections under the No Act.** *Start: 11/01/2022*
N883	**Alert: Processed according to state law** *Start: 11/01/2022*
N884	**Alert: The No Surprises Act may apply to this claim. Please contact payer for instructions on how to sub information regarding whether or not the item or service was furnished during a patient visit to a partic facility.** *Start: 11/01/2022*
N885	**Alert: This claim was not processed in accordance with the No Surprises Act cost-sharing or out-of-netw payment requirements. The payer disagrees with your determination that those requirements apply. Yo contact the payer to find out why it disagrees. You may appeal this adverse determination on behalf of through the payer's internal appeals and external review processes.** *Start: 11/01/2022*
N886	**Alert: A Health Care Claim Request for Additional Information (277 RFAI) has been sent.** *Start: 07/01/2023*
N887	**Providers not participating in the Medicare Advantage Plan have the right to appeal if the plan has part fully denied payment or if the provider believes the plan has not paid the services at the expected Med reimbursable rate or type of level/service. Providers may file their appeal in writing within 60 calendar the date of the remittance advice. For the plan to review the appeal, the plan will need a completed sig of Liability Statement. To obtain a Waiver of Liability form, please contact your Medicare Advantage Pla** **Once we receive the completed forms, we will give you a decision on your appeal within 60 calendar da** *Start: 07/01/2023*
N888	**Alert: An electronic request for additional information has been sent for this claim.** *Start: 07/01/2023*
N889	**Alert: This claim was originally processed in real-time, and we sent a real-time 835 response.** *Start: 11/01/2023*

N890	**Electronic Visit Verification Data Element Requirements were not met.** *Start: 11/01/2023*
N891	**The maximum allowable payment for this service/procedure was paid by the primary insurance. No fur payment due.** *Start: 11/01/2023*
N892	**The claim does not meet the criteria for acceptable use of the Delay Reason Code.** *Start: 11/01/2023*
N893	**Missing/incomplete/invalid child medical evaluation form/checklist.** *Start: 03/01/2024*
N894	**Alert: These payments are made subject to a reservation of rights for the Payor to recoup or otherwise or part of these payments based on any of the following: outcome of pending or future litigation/ new state, federal or regulatory guidance/ any other actions that may affect the Payor's obligation to make t payments.** *Start: 03/01/2024*
N895	**Processed based on a negotiated fee schedule for a specialty drug program.** *Start: 03/01/2024*
N896	**Missing/incomplete/invalid trauma activation sheet.** *Start: 07/01/2024*
N897	**Missing/incomplete/invalid proof of member payment.** *Start: 07/01/2024*
N898	**Missing/incomplete/invalid Resource Utilization Group(s) (RUG) code(s).** *Start: 07/01/2024*
N899	**Missing Initial Evaluation Report.** *Start: 07/01/2024*
N900	**Missing Therapy Notes/Report.** *Start: 07/01/2024*
N901	**Incomplete/Invalid Therapy Notes/Report.** *Start: 07/01/2024*
N902	**Missing Health Risk Assessment (HRA).** *Start: 07/01/2024*

N903	**Incomplete/Invalid Health Risk Assessment (HRA).** *Start: 07/01/2024*
N904	**The transportation vendor is responsible for this claim.** *Start: 07/01/2024*
N905	**Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is not responsible for** *Start: 03/01/2025*
N906	**Service is not covered when patient is under age 45.** *Start: 03/01/2025*
N907	**No refund because this claim has been identified as 340B-eligible with a ceiling price lower than the ma price.** *Start: 03/01/2025* *Notes: To be used with the Medicare Drug Price Negotiation Program only.*
N908	**No refund because this drug has been prospectively purchased at the maximum fair price.** *Start: 03/01/2025* *Notes: To be used with the Medicare Drug Price Negotiation Program only.*
N909	**Refund amount has been calculated using a methodology that differs from the Standard Default Refund calculation ((Wholesale Acquisition Cost minus Maximum Fair Price) times Quantity).** *Start: 03/01/2025* *Notes: To be used with the Medicare Drug Price Negotiation Program only.*
N910	**A refund cannot be provided for this claim at this time. Contact the manufacturer directly regarding you eligibility.** *Start: 03/01/2025* *Notes: To be used with the Medicare Drug Price Negotiation Program only.*
N911	**This claim cannot be reimbursed by the manufacturer until the Part D plan submits corrected prescripti event data to CMS for maximum fair price validation.** *Start: 03/01/2025* *Notes: To be used with the Medicare Drug Price Negotiation Program only.*