

Piedmont Reason Codes	HIPAA Reason Code	Reason Code Description
1	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
2	M2	Not paid separately when the patient is an inpatient.
3	M3	Equipment is the same or similar to equipment already being used.
4	M4	This is the last monthly installment payment for this durable medical equipment.
5	M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
6	M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
7	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
8	M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
9	M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
10	M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
11	M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
12	M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
13	M13	Only one initial visit is covered per specialty per medical group.
14	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
15	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
16	M16	Please see the letter or bulletin of (date) for further information.
17	M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
18	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.
19	M19	Missing/incomplete/invalid oxygen certification/re-certification.
20	M20	Missing/incomplete/invalid HCPCS.
21	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.
22	M22	Missing/incomplete/invalid number of miles traveled.
23	M23	Invoice needed for the cost of the material or contrast agent.
24	M24	Missing/incomplete/invalid number of doses per vial.
25	M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.

26	M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient 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 do not pay for this service, you should request review of this determination within 30 days of the date of this notice. You
27	M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) rega
28	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
29	M29	Missing/incomplete/invalid operative report.
30	M30	Missing/incomplete/invalid pathology report.
31	M31	Missing/incomplete/invalid radiology report.
32	M32	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
33	M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
34	M34	Claim lacks the CLIA certification number.
35	M35	Missing/incomplete/invalid pre-operative photos or visual field results.
36	M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
37	M37	Service not covered when the patient is under age 35.
38	M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
39	M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
40	M40	Claim must be assigned and must be filed by the practitioner's employer.
41	M41	We do not pay for this as the patient has no legal obligation to pay for this.
42	M42	The medical necessity form must be personally signed by the attending physician.
43	M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.
44	M44	Missing/incomplete/invalid condition code.
45	M45	Missing/incomplete/invalid occurrence codes or dates.
46	M46	Missing/incomplete/invalid occurrence span code or dates.
47	M47	Missing/incomplete/invalid internal or document control number.

48	M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
49	M49	Missing/incomplete/invalid value code(s) or amount(s).
50	M50	Missing/incomplete/invalid revenue code(s).
51	M51	Missing/incomplete/invalid procedure code(s) and/or dates.
52	M52	Missing/incomplete/invalid from date(s) of service.
53	M53	Missing/incomplete/invalid days or units of service.
54	M54	Missing/incomplete/invalid total charges.
55	M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
56	M56	Missing/incomplete/invalid payer identifier.
57	208	Missing/incomplete/invalid provider identifier.
58	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
59	M59	Missing/incomplete/invalid to date(s) of service.
60	M60	Missing/incomplete/invalid Certificate of Medical Necessity.
61	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
62	62	Missing/incomplete/invalid treatment authorization code.
63	B14	We do not pay for more than one of these on the same day.
64	M64	Missing/incomplete/invalid other diagnosis.
65	M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
66	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
67	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
68	M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
69	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
70	M70	NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
71	M71	Total payment reduced due to overlap of tests billed.
72	M72	Did not enter full 8-digit date (MM/DD/CCYY).
73	M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.
74	M74	This service does not qualify for a HPSA bonus payment.
75	M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
76	47	Missing/incomplete/invalid diagnosis or condition.
77	58	Missing/incomplete/invalid place of service.
78	M78	Missing/incomplete/invalid HCPCS modifier.
79	M79	Missing/incomplete/invalid charge.
80	M80	Not covered when performed during the same session/date as a previously processed service for the patient.
81	M81	You are required to code to the highest level of specificity.
82	M82	Service is not covered when patient is under age 50.
83	M83	Service is not covered unless the patient is classified as at high risk.
84	M84	Medical code sets used must be the codes in effect at the time of service

85	M85	Subjected to review of physician evaluation and management services.
86	M86	Service denied because payment already made for same/similar procedure within set time frame.
87	M87	Claim/service(s) subjected to CFO-CAP prepayment review.
88	M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
89	M89	Not covered more than once under age 40.
90	M90	Not covered more than once in a 12 month period.
91	M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
92	M92	Services subjected to review under the Home Health Medical Review Initiative.
93	M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
94	M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
95	M95	Services subjected to Home Health Initiative medical review/cost report audit.
96	M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
97	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
98	M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
99	M99	Missing/incomplete/invalid Universal Product Number/Serial Number.
100	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
101	M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
102	M102	Service not performed on equipment approved by the FDA for this purpose.
103	M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
104	M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
105	M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
106	M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
107	M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
108	M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
109	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.
110	M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
111	M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
112	M112	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

113	M113	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
114	M114	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
115	M115	This item is denied when provided to this patient by a non-demonstration supplier.
116	M116	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
117	M117	Not covered unless submitted via electronic claim.
118	M118	Letter to follow containing further information.
119	M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).
120	M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
121	M121	We pay for this service only when performed with a covered cryosurgical ablation.
122	M122	Missing/incomplete/invalid level of subluxation.
123	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
124	M124	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
125	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
126	M126	Missing/incomplete/invalid individual lab codes included in the test.
127	M127	Missing/incomplete/invalid patient medical record for this service.
128	M128	Missing/ incomplete/ invalid date of the patient's last physician visit.
129	M129	Missing/incomplete/invalid indicator of x-ray availability for review.
130	M130	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
131	M131	Missing/incomplete/invalid physician financial relationship form.
132	M132	Missing/incomplete/invalid pacemaker registration form.
133	M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
134	M134	Performed by a facility/supplier in which the provider has a financial interest.
135	M135	Missing/incomplete/invalid plan of treatment.
136	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
137	M137	Part B coinsurance under a demonstration project.
138	M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
139	M139	Denied services exceed the coverage limit for the demonstration.
140	M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday
141	M141	Missing/incomplete/invalid physician certified plan of care.
142	M142	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.
143	M143	We have no record that you are licensed to dispensed drugs in the State where located.
144	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

145	MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a profession
146	MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.
147	MA03	If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and th
148	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
149	MA05	Incorrect admission date patient status or type of bill entry on claim.
150	MA06	Missing/incomplete/invalid beginning and/or ending date(s).
151	MA07	The claim information has also been forwarded to Medicaid for review.
152	MA08	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
153	MA09	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
154	MA10	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
155	MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
156	MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
157	MA13	You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

158	MA14	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
159	MA15	Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
160	MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
161	MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
162	MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
163	MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
164	MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
165	MA21	SSA records indicate mismatch with name and sex.
166	MA22	Payment of less than \$1.00 suppressed.
167	MA23	Demand bill approved as result of medical review.
168	MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
169	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
170	MA26	Our records indicate that you were previously informed of this rule.
171	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.
172	MA28	Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
173	MA29	Missing/incomplete/invalid provider name, city, state, or zip code.
174	MA30	Missing/incomplete/invalid type of bill.
175	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
176	MA32	Missing/incomplete/invalid number of covered days during the billing period.
177	MA33	Missing/incomplete/invalid noncovered days during the billing period.
178	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
179	MA35	Missing/incomplete/invalid number of lifetime reserve days.
180	MA36	Missing/incomplete/invalid patient name.
181	MA37	Missing/incomplete/invalid patient's address.
182	MA38	Missing/incomplete/invalid birth date.
183	MA39	Missing/incomplete/invalid gender.
184	MA40	Missing/incomplete/invalid admission date.
185	MA41	Missing/incomplete/invalid admission type.
186	MA42	Missing/incomplete/invalid admission source.
187	MA43	Missing/incomplete/invalid patient status.
188	MA44	No appeal rights. Adjudicative decision based on law.
189	MA45	As previously advised, a portion or all of your payment is being held in a special account.
190	MA46	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
191	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 payment.
192	MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.

193	MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
194	MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
195	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
196	MA52	Missing/incomplete/invalid date.
197	MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
198	MA54	Physician certification or election consent for hospice care not received timely.
199	MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
200	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 payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
201	MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
202	MA58	Missing/incomplete/invalid release of information indicator.
203	MA59	The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
204	MA60	Missing/incomplete/invalid patient relationship to insured.
205	MA61	Missing/incomplete/invalid social security number or health insurance claim number.
206	MA62	Telephone review decision.
207	MA63	Missing/incomplete/invalid principal diagnosis.
208	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
209	MA65	Missing/incomplete/invalid admitting diagnosis.
210	MA66	Missing/incomplete/invalid principal procedure code or date.
211	MA67	Correction to a prior claim.
212	MA68	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
213	MA69	Missing/incomplete/invalid remarks.
214	MA70	Missing/incomplete/invalid provider representative signature.
215	MA71	Missing/incomplete/invalid provider representative signature date.
216	MA72	The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
217	MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
218	MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
219	MA75	Missing/incomplete/invalid patient or authorized representative signature.
220	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
221	MA77	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
222	MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
223	MA79	Billed in excess of interim rate.

224	MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
225	MA81	Missing/incomplete/invalid provider/supplier signature.
226	MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
227	MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
228	MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
229	MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
230	MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
231	MA87	Missing/incomplete/invalid insured's name for the primary payer.
232	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
233	MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
234	MA90	Missing/incomplete/invalid employment status code for the primary insured.
235	MA91	This determination is the result of the appeal you filed.
236	MA92	Missing/incomplete/invalid plan information for other insurance.
237	MA93	Non-PIP (Periodic Interim Payment) claim.
238	MA94	Did not enter the statement Attending physician not hospice employee on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.
239	MA95	De-activate and refer to M51.
240	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
241	MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.
242	MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
243	MA99	Missing/incomplete/invalid Medigap information.
244	MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.
245	MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
246	MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
247	MA103	Hemophilia Add On.
248	MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
249	MA105	Missing/incomplete/invalid provider number for this place of service.
250	MA106	PIP (Periodic Interim Payment) claim.
251	MA107	Paper claim contains more than three separate data items in field 19.
252	MA108	Paper claim contains more than one data item in field 23.
253	MA109	Claim processed in accordance with ambulatory surgical guidelines.
254	MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
255	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
256	MA112	Missing/incomplete/invalid group practice information.

257	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
258	MA114	Missing/incomplete/invalid information on where the services were furnished.
259	MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
260	MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.
261	MA117	This claim has been assessed a \$1.00 user fee.
262	MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
263	MA119	Provider level adjustment for late claim filing applies to this claim.
264	MA120	Missing/incomplete/invalid CLIA certification number.
265	MA121	Missing/incomplete/invalid date the x-ray was performed.
266	MA122	Missing/incomplete/invalid initial date actual treatment occurred.
267	MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
268	MA124	Processed for IME only.
269	MA125	Per legislation governing this program, payment constitutes payment in full.
270	MA126	Pancreas transplant not covered unless kidney transplant performed.
271	MA127	Reserved for future use.
272	MA128	Missing/incomplete/invalid six-digit FDA approved, identification number.
273	MA129	This provider was not certified for this procedure on this date of service.
274	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
275	MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
276	MA132	Adjustment to the pre-demonstration rate.
277	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
278	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
279	N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
280	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
281	N3	Missing/incomplete/invalid consent form.
282	N4	Missing/incomplete/invalid prior insurance carrier EOB.
283	N5	EOB received from previous payer. Claim not on file.
284	N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
285	N7	Processing of this claim/service has included consideration under Major Medical provisions.
286	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
287	71	Adjustment represents the estimated amount the primary payer may have paid.
288	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
289	N11	Denial reversed because of medical review.

290	N12	Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
291	N13	Payment based on professional/technical component modifier(s).
292	45	Payment adjusted based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
293	N15	Services for a newborn must be billed separately.
294	N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
295	N17	Per admission deductible.
296	N18	Payment based on the Medicare allowed amount.
297	N19	Procedure code incidental to primary procedure.
298	N20	Service not payable with other service rendered on the same date.
299	N21	Range of dates separated onto single lines.
300	N22	This procedure code was added/changed because it more accurately describes the services rendered.
301	N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
302	N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
303	N25	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
304	N26	Missing/incomplete/invalid itemized bill.
305	N27	Missing/incomplete/invalid treatment number.
306	N28	Consent form requirements not fulfilled.
307	N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.
308	N30	Patient ineligible for this service.
309	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.
310	N32	Claim must be submitted by the provider who rendered the service.
311	N33	No record of health check prior to initiation of treatment.
312	N34	Incorrect claim form for this service.
313	N35	Program integrity/utilization review decision.
314	N36	Claim must meet primary payer's processing requirements before we can consider payment.
315	N37	Missing/incomplete/invalid tooth number/letter.
316	N38	Missing/incomplete/invalid place of service.
317	N39	Procedure code is not compatible with tooth number/letter.
318	N40	Missing/incomplete/invalid x-ray.
319	N41	Authorization request denied.
320	N42	No record of mental health assessment.
321	N43	Bed hold or leave days exceeded.
322	N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.
323	N45	Payment based on authorized amount.
324	N46	Missing/incomplete/invalid admission hour.
325	N47	Claim conflicts with another inpatient stay.
326	N48	Claim information does not agree with information received from other insurance carrier.
327	N49	Court ordered coverage information needs validation.
328	N50	Missing/incomplete/invalid discharge information.
329	N51	Electronic interchange agreement not on file for provider/submitter.
330	31	Patient not enrolled in the billing provider's managed care plan on the date of service.
331	N53	Missing/incomplete/invalid point of pick-up address.
332	N54	Claim information is inconsistent with pre-certified/authorized services.

333	N55	Procedures for billing with group/referring/performing providers were not followed.
334	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
335	N57	Missing/incomplete/invalid prescribing/dispensed date.
336	N58	Missing/incomplete/invalid patient liability amount.
337	N59	Please refer to your provider manual for additional program and provider information.
338	N60	A valid NDC is required for payment of drug claims effective October 02.
339	N61	Rebill services on separate claims.
340	N62	Inpatient admission spans multiple rate periods. Resubmit separate claims.
341	N63	Rebill services on separate claim lines.
342	N64	The from and to dates must be different.
343	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
344	N66	Missing/incomplete/invalid documentation.
345	N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
346	N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
347	N69	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.
348	N70	Home health consolidated billing and payment applies.
349	N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
350	N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
351	N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.
352	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
353	N75	Missing/incomplete/invalid tooth surface information.
354	N76	Missing/incomplete/invalid number of riders.
355	N77	Missing/incomplete/invalid designated provider number.
356	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
357	N79	Service billed is not compatible with patient location information.
358	N80	Missing/incomplete/invalid prenatal screening information.
359	N81	Procedure billed is not compatible with tooth surface code.
360	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
361	N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
362	N84	Further installment payments forthcoming.
363	N85	Final installment payment.
364	N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
365	N87	Home use of biofeedback therapy is not covered.

366	N88	This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
367	N89	Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
368	N90	Covered only when performed by the attending physician.
369	N91	Services not included in the appeal review.
370	N92	This facility is not certified for digital mammography.
371	N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
372	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
373	N95	This provider type/provider specialty may not bill this service.
374	N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
375	N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
376	N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
377	N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
378	N100	PPS (Prospect Payment System) code corrected during adjudication.
379	N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
380	N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
381	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
382	N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov .
383	N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
384	N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
385	N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
386	N108	Missing/incomplete/invalid upgrade information.
387	N109	This claim was chosen for complex review and was denied after reviewing the medical records.
388	N110	This facility is not certified for film mammography.

389	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
390	N112	This claim is excluded from your electronic remittance advice.
391	N113	Only one initial visit is covered per physician, group practice or provider.
392	N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
393	N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD.
394	N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
395	N117	This service is paid only once in a patient's lifetime.
396	N118	This service is not paid if billed more than once every 28 days.
397	N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.
398	N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
399	N121	No coverage for items or services provided by this type of practitioner for patients in a covered Skilled Nursing Facility (SNF) stay.
400	N122	Mammography add-on code cannot be billed by itself.
401	N123	This is a split service and represents a portion of the units from the originally submitted service.
402	N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
403	N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.
404	N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
405	N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.
406	N128	This amount represents the prior to coverage portion of the allowance.
407	N129	This amount represents the dollar amount not eligible due to the patient's age.
408	N130	Consult plan benefit documents for information about restrictions for this service.

409	N131	Total payments under multiple contracts cannot exceed the allowance for this service.
410	N132	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
411	N133	Services for predetermination and services requesting payment are being processed separately.
412	N134	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
413	N135	Record fees are the patient's responsibility and limited to the specified co-payment.
414	N136	To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
415	N137	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.
416	N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
417	N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
418	N140	You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
419	N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
420	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
421	N143	The patient was not in a hospice program during all or part of the service dates billed.
422	N144	The rate changed during the dates of service billed.
423	N145	Missing/incomplete/invalid provider identifier for this place of service.
424	N146	Missing/incomplete/invalid/not approved screening document.
425	N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
426	N148	Missing/incomplete/invalid date of last menstrual period.
427	N149	Rebill all applicable services on a single claim.
428	N150	Missing/incomplete/invalid model number.
429	N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
430	N152	Missing/incomplete/invalid replacement claim information.
431	N153	Missing/incomplete/invalid room and board rate.
432	N154	This payment was delayed for correction of provider's mailing address.
433	N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
434	N156	The patient is responsible for the difference between the approved treatment and the elective treatment.
435	N157	Transportation to/from this destination is not covered.

436	N158	Transportation in a vehicle other than an ambulance is not covered.
437	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
438	N160	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
439	N161	This drug/service/supply is covered only when the associated service is covered.
440	N162	This is an 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 payment in the near future.
441	N163	Medical record does not support code billed per the code definition.
442	N164	Transportation to/from this destination is not covered.
443	N165	Transportation in a vehicle other than an ambulance is not covered.
444	N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
445	N167	Charges exceed the post-transplant coverage limit.
446	N168	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
447	N169	This drug/service/supply is covered only when the associated service is covered.
448	N170	A new/revised/renewed certificate of medical necessity is needed.
449	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.
450	N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
451	N173	No qualifying hospital stay dates were provided for this episode of care.
452	N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
453	N175	Missing/incomplete/invalid Review Organization Approval.
454	N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
455	N177	We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
456	N178	Missing/invalid/incomplete pre-operative photos or visual field results.
457	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
458	N180	This item or service does not meet the criteria for the category under which it was billed.
459	N181	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.
460	N182	This claim/service must be billed according to the schedule for this plan.
461	N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
462	N184	Rebill technical and professional components separately.
463	N185	Do not resubmit this claim/service.
464	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
465	N187	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
466	N188	The approved level of care does not match the procedure code submitted.
467	N189	This service has been paid as a one-time exception to the plan's benefit restrictions.
468	N190	Missing/incomplete/invalid contract indicator.
469	N191	The provider must update insurance information directly with payer.
470	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
471	N193	Specific federal/state/local program may cover this service through another payer.

472	N194	Technical component not paid if provider does not own the equipment used.
473	N195	The technical component must be billed separately.
474	N196	Patient eligible to apply for other coverage which may be primary.
475	N197	The subscriber must update insurance information directly with payer.
476	N198	Rendering provider must be affiliated with the pay-to provider.
477	N199	Additional payment approved based on payer-initiated review/audit.
478	N200	The professional component must be billed separately.
479	N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.
480	N202	Additional information/explanation will be sent separately
481	N203	Missing/incomplete/invalid anesthesia time/units
482	N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months
483	N205	Information provided was illegible
484	N206	The supporting documentation does not match the claim
485	N207	Missing/incomplete/invalid birth weight
486	N208	Missing/incomplete/invalid DRG code
487	N209	Missing/invalid/incomplete taxpayer identification number (TIN)
488	N210	You may appeal this decision
489	N211	You may not appeal this decision
490	N212	Charges processed under a Point of Service benefit
491	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information
492	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s)
493	N215	A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
494	N216	Patient is not enrolled in this portion of our benefit package
701	125	Contract Amount
702	125	Medicare Deductible
703	125	Amount Of Claim
704	125	Contract All Inclusive
705	125	Retrospective Review
706	125	Required Concurrent Review Missing
707	125	Required Discharge Summary Missing
708	125	Required Treatment Records Missing
709	125	Concurrent Review Incomplete - Treatment Dates
710	125	Concurrent Review Incomplete - Services Provided
711	125	Other-claim/service pending further review
712	125	Unclear Claim
713	125	Incomplete Claim
714	71	Other Primary Insurance Payment
715	125	Insurance Terminated
716	125	Dates of Service Not Authorized
717	125	Required Concurrent Review Not Received
718	125	Required Discharge Summary Not Received
719	125	Required Treatment Records Not Received
720	96	By Contract, Non-Covered Services
721	125	Claim Received After Billable Period
722	125	Not Responsible For Medical Services
723	125	Other - Non covered visits
724	125	No Record of Treatment
725	125	No Treatment Authorization

726	125	Incomplete/Inaccurate Authorization Dates
727	125	Multitreatments With Identical LOC's
728	125	Outpatient Treatment Contains Multiple LOC's
729	125	Other-Not covered unless provider accepts assignme
730	125	Other - Major Medical Adjustment
731	125	Admission Date Not Given/Inaccurate
732	125	Discharge Date Not Given/Inaccurate
733	125	LOC Inaccurate
734	125	Mental Health - 30 Day Stop Loss
735	125	Retrospective Review
736	125	Contract All Inclusive
737	125	Over Payment Adjustment
738	125	Under Payment Adjustment
739	125	Per Concurrent Review, No Service Performed
740	125	Service is Not Authorized
741	125	Number of Authorized Sessions Exceeded
742	125	Co-Insurance
743	125	Rate Information Inaccurate
744	125	EOB Missing
745	125	Evaluation Incomplete - Treatment Dates
746	125	Evaluation Incomplete - Services Provided
747	125	Required Evaluation Missing
748	125	Medicare Benefits Exhausted
749	125	Medicare Deductible Paid Previously
750	125	Number of Partial Hours Inaccurate
751	125	Non-Compliance With Authorization
752	125	Required Evaluation Not Received
753	125	Required Concurrent Review Incomplete
754	125	Required Evaluation Incomplete
755	125	Frequency of Authorization Exceeded
756	125	Authorization Ended
757	125	Service Document Not Received
758	125	Required EOB Missing
759	125	Required Documentation Not Received within 60 Days
760	125	No Show
761	125	Clinical Denial
762	125	Exceeded Amount
763	125	Pending Confirmation
764	125	Pending Validation
765	18	Duplicate Claim
766	125	Subcapitated Provider
767	125	Benefits Exhausted
768	125	Batch Denial
769	125	RU Number Not Authorized
770	125	Exceeded Provider Agreement Limit
771	125	Exceeded Provider Agreement Limit
772	125	Diagnosis does not correspond to authorized
773	125	Member not currently subcapped to this provider
774	125	No valid subcap agreement for this provider
775	125	Service not in Provider's Profile
776	125	Invalid Prov./Prov. Type/Medical Assistance Number

777	125	Invalid LOC/Provider Type/Service Type/CPT Code
778	125	Provider not Authorized for this Claims Matrix
779	125	No DRG found or DRG does not match Claims Matrix
780	125	Place of Service does not match Claims Matrix
781	125	Prim. Axis not found or no Match in Claims Matrix
782	125	Date of service not within treatment date range
783	125	Invalid Diagnosis Effective Date
784	125	Invalid Diagnosis/Sex Combination
785	125	Invalid Diagnosis/Age Combination
786	125	Invalid Bill Type
787	125	Rend by Provider not authorized to do this service
788	125	Invalid LOC/Modifier/Place of Service combination
789	125	Client in DSS Custody
790	125	Incorrect Member
791	125	Invalid Date Spans
792	125	Keying Error
793	125	Provider Billing Error
794	125	Invalid Place of Service
795	125	Invalid Units
796	125	Invalid CPT Code
797	125	Invalid Modifier
798	125	Therapeutic Leave Incl in RM & Brd/Res Svcs Billed
799	125	Treatment/Provider Error
800	125	Primary payment greater than PBH responsibility
801	125	Patient Responsibility
1016	6	Invalid Age Group / Service Combo
1017	109	Service not in contract
1018	110	Claim received after billing period
1019	119	Daily frequency exceeded
1020	119	Weekly frequency exceeded
1021	119	Monthly frequency exceeded
1022	125	Yearly frequency exceeded
1023	2	Adjusted Against Co-Insurance
1024	119	Max Basic Units Exhausted
1025	147	No rates available
1026	0	Contract Amount Approved
1027	181	Invalid Service or Service Discontinued
1032	62	Authorized units already consumed
1033	125	Contract amount approved & Withheld
1034	125	Revert - Provider Billing Error
1035	125	Revert - Keying Error
1036	125	Revert - Audit Payback
1037	71	Revert - Other Primary Insurance
1038	62	Revert - Authorization/Treatment Revisions
1039	2	Revert - Patient Liability
1040	125	Revert - Billing Terms Revised
1041	62	Revert - Additional Units Billed
1042	125	Revert - Provider Agreement Revised
1043	125	Revert - Third Party Coverage Changes
1044	125	Revert - Not Included In Service Profile
1045	36	Revert - Primary Payment Greater Than PBH Responsibility

1046	125	Revert - Other
1047	125	Readju - Provider Billing Error
1048	125	Readju - Keying Error
1049	125	Readju - Audit Payback
1050	71	Readju - Other Primary Insurance
1051	62	Readju - Authorization/Treatment Revisions
1052	2	Readju - Patient Liability
1053	125	Readju - Billing Terms Revised
1054	125	Readju - Additional Units Billed
1055	125	Readju - Provider Agreement Revised
1056	125	Readju - Third Party Coverage Changes
1057	125	Readju - Not Included In Service Profile
1058	125	Readju - Primary Payment Greater Than PBH Responsibility
1059	125	Readju - Other
1060	125	Overid - Provider Billing Error
1061	125	Overid - Keying Error
1062	125	Overid - Audit Payback
1063	71	Overid - Other Primary Insurance
1064	62	Overid - Authorization/Treatment Revisions
1065	2	Overid - Patient Liability
1066	125	Overid - Billing Terms Revised
1067	125	Overid - Additional Units Billed
1068	125	Overid - Provider Agreement Revised
1069	125	Overid - Third Party Coverage Changes
1070	125	Overid - Not Included In Service Profile
1071	36	Overid - Primary Payment Greater Than PBH Responsibility
1072	125	Overid - Other
1073	23	Client has other covered insurance (COB)
1074	125	Invalid Amount
1075	125	Invalid Service / POS combination.
1076	11	Invalid DRG DX Code
1077	81	Discharged - Service cannot be paid
1078	17	Invalid Revenue Code
1079	109	No contract exists or rate is not set up yet
1080	18	Revert - Duplicate Claims
1081	22	Revert - EOB Required
1082	18	Readju - Duplicate Claims
1083	125	Readju - EOB Required
1084	18	Overid - Duplicate Claims
1085	22	Overid - EOB Required
1086	125	Readju - Rate Change
1087	125	Overid - Rate Change
1088	125	Revert - Contract Terminated
1089	125	Overid - Contract Terminated
1090	125	Readju - Contract Terminated
1091	63	Readju - Corrected Claim
1092	125	Readju - Audit Payback
1093	125	Readju - Audit Recoup
1094	63	Overid - Corrected Claim
1095	125	Overid - Audit Payback
1096	125	Overid - Audit Recoup

1097	63	Revert - Corrected Claim
1098	125	Revert - Audit Payback
1099	125	Revert - Audit Recoup
1100	45	Excess amount over allowed medicare copayment
1101	125	Invalid provider NPI number
1102	125	Invalid rendering provider NPI number
1103	125	Readju - Client Manually Matched
1104	125	Readju - Provider ID Incorrect
1105	109	Service not in State Contract
1106	125	Claim submitted before service date
1107	62	Overid - Missing/incomplete/invalid treatment authorization code
1108	181	Non billable service
1109	125	NPI implementation date revised
1110	125	Readju - NPI implementation date revised
1111	125	Overid - NPI implementation date revised
1112	125	Medicaid coverage changes for state denial
1113	125	Readju - Medicaid coverage changes for state denial
1114	125	Overid - Medicaid coverage changes for state denial
1115	119	Overid - Service frequency not exceeded
1116	125	Readju - Service frequency not exceeded
1117	125	Client Medicaid Out of Catchment Area
1118	125	Client Medicaid Out of Catchment Area
1119	125	Billing Days Extended
1120	125	Readju- Funding Source change from State to Medicaid
1121	125	Readju- Funding Source change from Medicaid to State
1122	125	Overid- Funding Source change from State to Medicaid
1123	125	Overid- Funding Source change from Medicaid to State
1124	125	Readju - Patient not enrolled in the billing provider's managed care plan on the date of service.
1125	125	Readju - patient outside PBH five county catchments area.
1126	125	Invalid DCN (Document Ctrl #) or resubmission ref #
1127	63	Revert - Reverted because reversal/replacement claim has been submitted
1128	125	Override- SIS Provider
1129	125	Revert-State Funds not in Provider Contract
1130	147	Clinician not licesed to provide the service or license has expired
1131	M59	Invalid date span for discharge claim
1132	125	Not Medicaid Elig/Out of Catchment
1133	125	Readju - Retroactive Medicaid
1134	125	FFS claim pended for 14 days wait
1135	109	Client no covered under contract
1136	125	Reversal request claim. Voided
1137	125	Resubmitted claim DOS is after original claim submission date
1138	125	Resubmitted claim seems unrelated to original claim
1139	N118	Monthly case rate already paid
1140	125	Referenced claims has already been resubmitted. Cannot resubmit again
1141	2	Override - Medicaid Deductible