CHAPTER 2
ADDENDUM H

DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/ prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed proven to be effective by the payer.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
60	Charges for outpatient services with this proximity to inpatient services are not covered.
89	Professional fees removed from charges.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
119	Benefit maximum for this time period has been reached.
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
149	Lifetime benefit maximum has been reached for this service/benefit category.
155	This claim is denied because the patient refused the service/procedure.
A1	Claim denied charges.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.
B9	Services not covered because the patient is enrolled in a Hospice.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
SAB8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	

FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.
78	Non-Covered days/Room charge adjustment.
108	Payment reduced because rent/purchase guidelines were not met.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using remittance advice remarks codes whenever appropriate.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support his length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002	

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Co-payment amount
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier amount - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
85	Interest amount.
87	Transfer amount.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	

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

ADJUST/DENIAL REASON CODE	DESCRIPTION
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
118	Charges reduced for ESRD network support.
121	Indemnification adjustment.
122	Psychiatric reduction.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
145	Premium payment withholding.
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A7	Presumptive Payment Adjustment
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B16	Payment adjusted because 'New Patient' qualifications were not met.
B22	This payment is adjusted based on the diagnosis.
W1	Workers Compensation State Fee Schedule Adjustment
HIPAA Standard Adjustment Reason Codes Release 06/01/2002.	