CLAIM DENIAL CODES LIST

as of 08/14/2023

CARC Code	Claim Adjustment Reason Code (CARC) Description	RARC Code	Remittance Advice Remark Code (RARC) Description	Medicaid Error Code	Medicaid Error Code Description	CORE Business Scenario
3	Co-payment Amount			2009	Spenddown applied amount greater than Medicaid allowed amount	-
				2010	Spenddown - possible match	
4	The procedure code is inconsistent with the modifier used.	N519	Invalid combination of HCPCS modifiers.	5521	Invalid procedure to modifier	2
				5352	Invalid modifier for procedure code.	
				5526	Invalid transportation modifier	
				5527	Procedure requires transportation modifier	
4	The procedure code is inconsistent with the modifier used.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	2005	Missing Ambulance Service modifier(s)	2
5	The procedure code/type of bill is inconsistent with the place of service.	M77	Missing/incomplete/invalid/inappropriate place of service.	20161	Hospice patient not residing in Nursing Facility	3
6	The procedure/revenue code is inconsistent with the patient's age.	N129	Not eligible due to the patient's age.	5559	Porcelain crown non covered for member's age	3
				1739	Procedure inconsistent with Member's age	
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	1343	Procedure not payable to Provider	3
9	The diagnosis is inconsistent with the patient's age.	N129	Not eligible due to the patient's age.	1127	Diagnosis inconsistent with Member's age	3
11	The diagnosis is inconsistent with the procedure.	N657	This should be billed with the appropriate code for these services.	1922	Diagnosis Inconsistent with ESRD Procedure code	3
				1307	Diagnosis is inconsistent with procedure code	
				5541	Noncovered Procedure combination with a Developmental Disorder Diagnosis	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M20	Missing/incomplete/invalid HCPCS.	1978	ESRD requires HCPCS code	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M22	Missing/incomplete/invalid number of miles traveled.	1923	Invalid number of miles (units)	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M50	Missing/incomplete/invalid revenue code(s).	2047	Missing revenue code.	2
				5537	Noncovered Revenue Code	
				2050	Revenue code not on file	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M51	Missing/incomplete/invalid procedure code(s).	1841	Procedure code invalid or not approved in reference file	2
				5538	Revenue code requires HCPCS code	
				2056	Missing procedure code	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M53	Missing/incomplete/invalid days or units of service.	5530	Units are greater than number of service days	2
				2057	Missing units of service.	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M62	Missing/incomplete/invalid treatment authorization code.	5534	Missing/Invalid Prior Authorization	2
				1975	Missing Admission record (Nursing Facility/ICF/ID)	
				5044	Diagnosis requires prior authorization	
				5522	Missing or invalid prior authorization number for Inpatient psychiatric services	
				1883	Missing NCW/EPAS authorization for PRISM claim	
				5049	Missing/invalid prior authorization for Surgical Procedure	
				5050	Missing/invalid Prior Authorization for Abortion Diagnosis	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M67	Missing/incomplete/invalid other procedure code(s).	5509	Invalid procedure billed for prolonged care claim.	2
				1919	Missing ICD Surgical code	
				1957	Only incidental services reported on an Outpatient claim	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M76	Missing/incomplete/invalid diagnosis or condition	2030	Invalid diagnosis code	2
				20170	Diagnosis code Missing/Invalid	
				1910	Missing diagnosis pointer or invalid diagnosis associated to the pointer	

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M77	Missing/incomplete/invalid/inappropriate place of service.	1847	Invalid place of service	2
				2083	Place of service missing	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	5505	Invalid NDC for date of service	2
				5504	Missing/Invalid NDC	
				1285	NDC invalid for procedure	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	1880	Invalid unit of measure or quantity for NDC	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	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.	2015	COB information is out of balance	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1025	Line level date of service does not fall within claim level date of service.	2
				2046	Missing/invalid date of service	
				2036	First date of service greater than last date of service.	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	20132	Covered days missing	2
				1803	Invalid total days	
				2044	Covered days not equal to Room and Board units billed	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA39	Missing/incomplete/invalid gender.	1128	Diagnosis inconsistent with Member's gender	2
				1146	Procedure inconsistent with Member's gender	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA40	Missing/incomplete/invalid admission date.	1913	Admit date more than 3 days after the from Date of service	2
				1916	Missing admission date	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA41	Missing/incomplete/invalid admission type.	20163	Admit type is missing/invalid	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA42	Missing/incomplete/invalid admission source.	1911	Missing/Invalid Admission Source	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA63	Missing/incomplete/invalid principal diagnosis.	20157	Primary Diagnosis code Missing	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA65	Missing/incomplete/invalid admitting diagnosis.	1917	Missing admitting diagnosis	2
				20164	Admitting diagnosis code invalid	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA66	Missing/incomplete/invalid principal procedure code.	1926	Missing parent code for add-on code	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA120	Missing/incomplete/invalid CLIA certification number.	5315	Invalid CLIA number for Provider/Location	2
				1071	Missing CLIA certificate number	
				5369	Invalid CLIA certificate Number	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N34	Incorrect claim form/format for this service.	1716	Unable to determine the Benefit Plan due to claim type restriction	2
				1008	Unable to determine claim type	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N37	Missing/incomplete/invalid tooth number/letter.	1914	Missing tooth number	2
				2067	Dental procedure not eligible due to a tooth extraction	
				2020	Missing tooth number	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N39	Procedure code is not compatible with tooth number/letter.	1140	Invalid tooth number for the procedure code	2
				1183	Procedure code/tooth number conflict	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N46	Missing/incomplete/invalid admission hour.	1010	Missing/Invalid admission hour	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N50	Missing/incomplete/invalid discharge information.	1846	Invalid discharge date	2
				1918	Invalid discharge status	

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N54	Claim information is inconsistent with pre-certified/authorized services.	5193	Invalid NPI for BP	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N54	Claim information is inconsistent with pre-certified/authorized services.	5054	Invalid Prior authorization or PA to Member mismatch	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	5528	Discontinued procedure code	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N62	Dates of service span multiple rate periods. Resubmit separate claims.	1036	Line Dates of Service span across calendar year	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N63	Rebill services on separate claim lines.	1834	LT and RT modifiers must be billed on separate lines	2
				1937	CPT surgical code from and to date must be the same	
				5362	Dates of service cannot overlap calendar months	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N75	Missing/incomplete/invalid tooth surface information.	1833	Invalid number or tooth surfaces for restoration	2
				2021	Missing tooth surface	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N208	Missing/incomplete/invalid DRG code.	1850	Invalid DRG principal diagnosis	2
				1976	Unable to assign a DRG	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N251	Missing/incomplete/invalid attending provider taxonomy.	5380	Invalid Attending Provider NPI	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N253	Missing/incomplete/invalid attending provider primary identifier.	5326	Invalid Attending Provider cannot be a group	2
				1125	Missing Attending Provider NPI	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N257	Missing/incomplete/invalid billing provider/ supplier primary identifier.	5311	Billing Provider due to Applicant Type.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N261	Missing/incomplete/invalid operating provider name.	1132	Missing Operating Provider NPI	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N265	Missing/incomplete/invalid ordering provider primary identifier.	5374	Missing Ordering Provider for Med-Vendor	2
				5376	Missing/Invalid Ordering Provider for Home Health	
				5386	Missing/Invalid Ordering Provider for Lab and X-ray	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N286	Missing/incomplete/invalid referring provider primary identifier.	5383	Invalid Operating Provider NPI	2
				1795	Missing/invalid referring provider NPI for a Member on restriction	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N290	Missing/incomplete/invalid rendering provider primary identifier.	5322	Invalid Rendering Provider	2
				5319	Missing Servicing (Rendering) Provider NPI	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N305	Missing/incomplete/invalid injury/accident date.	20180	Accident date after last date of service.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N308	Missing/incomplete/invalid appliance placement date.	1024	Missing appliance placement date for orthodontia.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N317	Missing/incomplete/invalid discharge hour.	2055	Missing/Invalid discharge hour	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N318	Missing/incomplete/invalid discharge or end of care date.	1930	Missing discharge date	2
				2006	Date of death less than discharge date	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N329	Missing/incomplete/invalid patient birth date.	2063	Invalid date of birth	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N330	Missing/incomplete/invalid patient death date.	1851	Missing or invalid member date of death	2

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N341	Missing/incomplete/invalid surgery date.	2037	Missing date of surgery	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N346	Missing/incomplete/invalid oral cavity designation code.	1143	Missing Dental quadrant or arch (Oral Cavity)	2
				2039	Invalid oral cavity for procedure code	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N382	Missing/incomplete/invalid patient identifier.	2022	Missing Member ID	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N434	Missing/Incomplete/Invalid Present on Admission indicator.	5345	Diagnosis not present on admission for Inpatient claim	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1868	Invalid line level TPL information - Out of balance	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N519	Invalid combination of HCPCS modifiers.	2084	Modifier 1 invalid	2
				2085	Modifier 2 invalid	
				2086	Modifier 3 invalid	
				2087	Modifier 4 invalid	
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	1727	Unable to determine the Benefit Plan due to modifier restriction	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N823	Incomplete/Invalid procedure modifier(s).	20158	Non-covered Modifier	2
18	Exact duplicate claim/service.			20171	Inpatient Claim for Member with Medicare Part B Only coverage	2
18	Exact duplicate claim/service.	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	2013	Replacement claim (orig claim not found)	2
18	Exact duplicate claim/service.	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	2043	Manually denied as a duplicate	2
				1225	Exact duplicate of a Paid claim/line	
22	This care may be covered by another payer per coordination of benefits.			1946	Member has medical insurance	3
				2045	Member has medical insurance - Attachment	
22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.	1816	Member has medical insurance	3
22	This care may be covered by another payer per coordination of benefits.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	5359	Service denied by Medicare, non-covered through crossovers	3
22	This care may be covered by another payer per coordination of benefits.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1184	Medicare within date(s) of service	3
26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	1999	Member is not eligible - Spenddown not met	3
				2000	Member is not eligible for all service dates - Spenddown not met	
29	The time limit for filing has expired.			1936	Date(s) of service exceeds 3 years	3
35	Lifetime benefit maximum has been reached.	N117	This service is paid only once in a patient's lifetime.	1375	Denture - Exceeds limit of 1 immediate denture per Member.	3
				5341	TCM initial evaluation - Exceeds limit of 1 per lifetime per provider	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1925	Emergency Services Program for Non-Citizens - Attachment Available	3
				1700	Manually denied after review	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5520	Early elective delivery not allowed.	3
54	Multiple physicians/assistants are not covered in this case.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	1240	Multiple Surgeons/Assistant Surgeon not allowed	3
				5524	Assistant Surgeon not covered	

58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N760	This facility is not authorized to receive payment for the service(s).	1953	Inpatient services billed on an Outpatient claim (OCE edits 0018, 0045 and 0049)	3
				1970	Invalid Place of Service for inpatient only procedure	
				20167	Invalid Place of Service	
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.			5347	Inpatient claim conflict with Outpatient claim having a DOS within 3 days of Inpatient admit.	3
				1968	FFS Inpatient DRG/Outpatient claim conflict	
60	Charges for outpatient services not covered when performed within a period of time prior to or after inpatient services.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	1967	FFS Outpatient/Inpatient DRG claim conflict	3
95	Plan procedures not followed.	N182	This claim/service must be billed according to the schedule for this plan.	2040	Billing deadline exceeded - No attachment	3
96	Non-covered charge(s).	M2	Not paid separately when the patient is an inpatient.	1865	Inpatient Hospital Conflict to Paid Medical Claim	3
				1949	Inpatient claim conflict with Aging Waiver claim	
				1959	Inpatient services conflict with Home and Community Based Services claim	
				1962	Inpatient, NH, ICF/ID services conflict with another procedure.	
				1952	Inpatient claim conflict with Targeted Case Management claim	
				5360	Outpatient/Inpatient DRG claim conflict	
				5361	Inpatient DRG/Outpatient claim conflict	
				2017	Professional Services not covered - Member is in the hospital	
				5357	Occupational therapy services is included in Inpatient claim payment	
				1950	Aging Waiver claim conflict with Inpatient/Nursing Home stay	
				1951	Targeted case management overlaps Inpatient/Nursing Home stay	
				1961	Home and Community Based Services conflict with Inpatient/Nursing Home services	
				1964	Dates of service overlap a claim billed on an Inpatient claim.	
				5536	Service not covered while the Member is in the hospital	
96	Non-covered charge(s).	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	1845	Personal Care/Home Health services conflict	3
				2065	Dental procedure combination not expected.	
96	Non-covered charge(s).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	5523	Suspend all claims with this procedure	3
				5351	Suspend all claims for Billing Provider	
				2019	Claim Super Suspend	
				2007	POA DX for a DRG Claim requires medical review - Attachment available	
				5325	Suspend all claims for Servicing Provider	
96	Non-covered charge(s).	N30	Patient ineligible for this service.	1931	Member not eligible for all dates of service	3
				1932	Member not eligible for all line level dates of service	
				1934	Member is not eligible on the date of service	
				1974	Custody medical care claims	
				5557	Procedure code not covered on date of service.	
96	Non-covered charge(s).	N39	Procedure code is not compatible with tooth number/letter.	1985	Root canals not covered for this tooth	3
96	Non-covered charge(s).	N54	Claim information is inconsistent with pre-certified/authorized services.	5040	Prior Authorization is not in Approved status.	3
96	Non-covered charge(s).	N129	Not eligible due to the patient's age.	5344	Member not eligible for procedure/organic diagnosis combination	3
96	Non-covered charge(s).	N161	This drug/service/supply is covered only when the associated service is covered.	1958	Invalid vaccine and/or administration codes. Coordinating vaccine and admin codes must be submitted.	3
96	Non-covered charge(s).	N198	Rendering provider must be affiliated with the pay-to provider.	5356	Servicing provider unaffiliated with group practice	3

96	Non-covered charge(s).	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	1717	Unable to determine the Benefit Plan due to procedure code restriction	3
				1718	Unable to determine the Benefit Plan due to revenue code restriction	
				1719	Unable to determine the Benefit Plan due to surgical code restriction	
				1720	Unable to determine the Benefit Plan due to diagnosis code restriction	
				5544	ER visit for PCN client is not an emergency	
				1997	Non-covered diagnosis for PCN client Emergency Department visit	
96	Non-covered charge(s).	N424	Patient does not reside in the geographic area required for this type of payment.	1724	Unable to determine the Benefit Plan due to member county restriction	3
96	Non-covered charge(s).	N431	Not covered with this procedure.	1929	Procedure code not covered on date of service	3
				1849	Non-covered surgical procedure	
				5540	Reference file - Suspend for review	
96	Non-covered charge(s).	N569	Not covered when performed for the reported diagnosis.	1944	Diagnosis is not covered by Medicaid	3
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	1869	NDC is non-rebateable	3
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M2	Not paid separately when the patient is an inpatient.	1963	Procedure conflict with Inpatient/NH services	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	2064	Payment included in another service	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	2066	Dental code is mutually exclusive of another code	4
				5550	Bundled Service vs Unbundled Service	
				5553	Bundled Service H0012 vs Unbundled Service	
				5551	Unbundled Service vs Bundled Service	
				5552	Unbundled Service vs Bundled Service H0012	
				5554	Bundled Service vs Bundled Service	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	Service denied because payment already made for same/similar procedure within set time frame.	1861	Global/other delivery conflict	4
				1990	Global maternity claim conflict to maternity service claim	
				1993	Antepartum conflict	
				1995	Global cognitive or lab service and global maternity claim conflict	
				1863	Global Maternity Care conflict with paid Delivery claim	
				1864	Antepartum or postpartum and global maternity claim conflict	
				5511	A bundled service for Lab Panels or Biological lines have been processed	
				1862	Global already paid	
				5506	Postpartum Care conflict	
				1989	Delivery Only Maternity claim conflict	
				1991	One Global Maternity Service Allowed in a 42 Day Period	
				1992	Global Maternity Care paid	
				1994	One delivery only including postpartum maternity service allowed in a 42 day period	
				1996	Global maternity claim and global cognitive or lab service conflict	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	1836	Technical component not allowed in this facility type.	4
				5535	Non-covered service while inpatient	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.	1799	Procedure is incidental (Status B) to another procedure on a history claim	4
				1797	Procedure is incidental (Status B) to another procedure on the same claim	

97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	**N20**	Service not payable with other service rendered on the same date.	**5318**	Injection is part of aspiration	4
				5332	Multiple nursing visits on the same date of service	
				5333	Extended supportive maintenance/nurse visit conflict	
				5334	Mulitple or mixed home health aide visits on the same day	
				5336	Skilled nursing/supportive maintenance/home health aide conflict	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	**N525**	These services are not covered when performed within the global period of another service.	**1969**	Services included in the global period	4
107	The related or qualifying claim/service was not identified on this claim.	**MA66**	Missing/incomplete/invalid principal procedure code.	**1933**	Anesthesia related or qualifying service not found	2
107	The related or qualifying claim/service was not identified on this claim.	**N674**	Not covered unless a pre-requisite procedure/service has been provided.	**5545**	Invalid VFC vaccine and/or administration. Coordinating vaccine and admin codes must be submitted.	2
108	Rent/purchase guidelines were not met.	**N370**	Billing exceeds the rental months covered/approved by the payer.	**5512**	Rental/Purchase guidelines not met	3
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**N418**	Misrouted claim. See the payer's claim submission instructions.	**5532**	Service covered under Mental Health contract	3
				5533	Service covered under Substance Use Disorder (SUD) contract	
				1935	Member enrolled in Dental Managed Care Program	
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**N747**	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.	**1965**	Service covered by Hospice agency	3
				1998	Client is enrolled in HOME	
				1387	Client is enrolled in a Medical Managed Care Plan	
				5558	Client is enrolled in an Integrated Manage Care Plan	
110	Billing date predates service date.	**M52**	Missing/incomplete/invalid "from" date(s) of service.	**2034**	Date of service is after the date the claim was received.	2
				2035	Billing date predates service date(s).	
119	Benefit maximum for this time period or occurrence has been reached.	**M86**	Service denied because payment already made for same/similar procedure within set time frame.	**1853**	Newborn care conflict	3
				1892	Respite care - Exceeds limit of 1 per day	
				1893	School District services - Exceeds limit of 1 per day	
				1894	Day treatment habilitation services - Exceeds limit of 1 per day	
				1896	Residential services - Exceeds limit of 1 per day	
				1939	Limit One physician visit per day	
				5364	Only one interim bill allowed per admission	
				1897	Face mask - Exceeds limit of 2 per year	
				1899	Sealant - Exceeds limit per tooth of 1 in 2 years	
				1900	Sling - Exceeds limit of 1 per month	
				1901	Risk assessment services - Exceeds limit of 2 per 10 months	
				1902	Group pre/postnatal education - Exceeds limit or 8 per 12 months	
				1903	Interim Caries - Exceeds limit of 1 in 180 days per tooth	
				1904	Psychosocial counseling - Exceeds limit of 12 per 12 months	
				1905	Pre/postnatal home visits - Exceeds limit of 6 per 12 months	
				5338	Dental x-ray limit exceeded (Complete series/panoramic)	
				5339	Dental x-ray limit exceeded (Bitewing/Complete Series)	
				5340	Core buildup/pin retention -Exceeds per tooth limit of 1 per day	
				2069	Exceeds dental limits for rolling years	
				2070	Duplicate Dental procedure exceeds unit limit	
119	Benefit maximum for this time period or occurrence has been reached.	**M90**	Not covered more than once in a 12 month period.	**5330**	Preventative health exam - Exceeds limit of 1 per year	3
				5335	Vision exam - Exceeds limit of 1 per year	
				1906	Smoking cessation - Exceeds limit per year	
119	Benefit maximum for this time period or occurrence has been reached.	**N362**	The number of Days or Units of Service exceeds our acceptable maximum	**5055**	Unit limit exceeded. No prior authorization found for additional units.	3
				1878	Exceeds orthodontia limits - IHS provider	
				1891	Observation services - Exceeds limit of 1 per 48 hours	
				1927	Excessive number of units submitted	
				1981	Exceeds a limit per calendar year for this procedure	
				1982	Respite care - Exceeds limit of 5 consecutive days	
				20160	Procedure has unit limit per year	
119	Benefit maximum for this time period or occurrence has been reached.	**N435**	Exceeds number/frequency approved/allowed within time period without support documentation.	**5342**	Pregnancy ultrasound - Exceeds limit of 10 per 12 months	3

119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	1855	HPV vaccine - Exceeds limit of 3 in a lifetime	3
				1856	Cast post and core/crown buildup - Exceeds limit of 1 in 5 years	
				1835	Depo Provera - Exceeds limit of once every 85 days	
				1857	Hyaluronates - Exceeds limit of 6 units per knee every 180 days	
				1858	Diabetes Education - Exceeds limit of 10 per 12 months	
				1859	Implanon - Exceeds limit of 1 every 3 years	
				2071	Newborn assessment - Exceeds limit of 1 per month	
				5327	Home Health initial visit - Exceeds limit of 1 per admission	
				5328	Home Health supplies - Exceeds allowable limit	
				1888	Lithotripsy - Exceeds limit of 2 per 90 days	
				5323	Team E&M - Exceeds limit of 1 per Calendar Month	
				5560	IMD Psych exceeds 60 day limit	
133	The disposition of this service line is pending further review.			1384	Account Code Assignment Failure	-
140	Patient/Insured health identification number and name do not match	MA36	Missing/incomplete/invalid patient name.	2004	Invalid Member name	2
140	Patient/Insured health identification number and name do not match	N382	Missing/incomplete/invalid patient identifier.	2058	Invalid Member ID	2
146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition	1110	Diagnosis invalid for date of service	2
147	Provider contracted/negotiated rate expired or not on file.			5346	LTAC rate not found	-
149	Lifetime benefit maximum has been reached for this service/benefit category.	N117	This service is paid only once in a patient's lifetime.	1960	Procedure exceeds Lifetime Limit	3
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N850	Missing/incomplete/invalid narrative explaining/describing this service/treatment.	1886	Documentation not received timely for reported Attachment Control Number	1
170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	5384	Unable to determine the Benefit Plan due to PT/SP/SSP restriction	3
				5365	Radiology procedure limited to radiology specialty	
				1988	Lab code limited to pathology specialty	
				1725	Unable to determine the Benefit Plan due to provider ID restriction	
171	Payment is denied when performed/billed by this type of provider in this type of facility.	N428	Not covered when performed in this place of service.	1977	Non-covered Hospital Based Clinic revenue code	3
177	Patient has not met the required eligibility requirements.			2001	Member is not eligible on service date - Attachment available	3
181	Procedure code was invalid on the date of service.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1941	Procedure code not valid for date(s) of service	2
				2053	Invalid procedure code	
				1170	Invalid surgical code for Date of Service	
				2008	Invalid Rev code for date of service	
183	The referring provider is not eligible to refer the service billed.	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider.	5547	Provider is not authorized to refer for Lab services	3
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N767	The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	5312	Ordering Provider not enrolled for date of service	3
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	1971	Services are covered in the ICF/ID per diem	4
				5529	Service is included in flat rate payment to the nursing home where Member resides	
197	Precertification/authorization/notification/pre-treatment absent.			1882	Missing NCW/EPAS authorization for converted claim adjustment	3
198	Precertification/notification/authorization/pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.	1121	Prior authorization Date mismatch	3
198	Precertification/notification/authorization/pre-treatment exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	1123	No available units/amounts on prior authorization	3
198	Precertification/notification/authorization/pre-treatment exceeded.	N435	Exceeds number/frequency approved/allowed within time period without support documentation.	5542	Units exceed approve PA units for a psychiatric stay	3

199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	2012	Incorrect billing of Rev Code with HCPCS	2
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N428	Not covered when performed in this place of service.	1983	Baby Your Baby (BYB) cannot be determined due to Benefit Plan Restrictions	3
				1723	Unable to determine the Benefit Plan due to place of service restriction	
216	Based on the findings of a review organization.			5042	Prior authorization manual pricing required for Legacy claim adjustment/resurrection	-
				1843	Allowed amount is greater than the defined threshold	
				5043	Miscellaneous code requires manual pricing - PA available	
				1885	Procedure requires manual pricing - Attachment	
				1217	Timely Filing - Attachment available	
				1921	DJJS Medical Claim	
216	Based on the findings of a review organization.			1332	Unable to price for the date of service	
				1940	Charge Mode error	
				5370	OIG Stop Payment	
				5556	Bundled service with paid unbundled service.	
216	Based on the findings of a review organization.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1852	DRG status is Suspend	-
				1873	Diagnosis requires manual review - Attachment available	
				5525	Modifier requires manual review - Attachment available	
				1947	Procedure requires manual review - Attachment available	
234	This procedure is not paid separately.	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient ony received an injection.	5317	Injection/office visit conflict	4
				1890	Therapeutic injection/office visit conflict	
234	This procedure is not paid separately.	N20	Service not payable with other service rendered on the same date.	1373	Contrast material not paid separately for MRZ/MRI/CT procedure with contrast	4
				2068	Contrast material not paid separately for MRZ/MRI/CT procedure without contrast	
				1798	Mutually Exclusive to another procedure on a paid history claim	
234	This procedure is not paid separately.	N390	This service/report cannot be billed separately.	5354	Services not paid when unbundled	4
242	Services not provided by network/primary care providers.	N767	The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	5320	Servicing provider not enrolled on date of service	3
251	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	N28	Consent form requirements not fulfilled.	1884	Invalid sterilization consent date	1
252	An attachment/other documentation is required to adjudicate this claim/service.	M23	Missing Invoice.	1948	Manual pricing - No attachment	1
252	An attachment/other documentation is required to adjudicate this claim/service.	M127	Missing patient medical record for this service.	1887	POA DX for a DRG Claim requires medical review - No Attachment	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N26	Missing itemized bill/statement.	1867	DME Manual pricing - No attachment	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N28	Consent form requirements not fulfilled.	2096	Missing Wheelchair Final Eval Form Date	1
				5051	Missing sterilization consent form	
				5052	Missing consent to abortion form	
				5053	Missing hospital surgical consent form	
252	An attachment/other documentation is required to adjudicate this claim/service.	N706	Missing documentation.	1874	Diagnosis requires manual review - No Attachment	1
				1875	Procedure requires manual review - No Attachment	
				1924	Modifier requires manual review - No attachment	
				1973	Documentation required for Emergency Services Program for Non-Citizens - No attachment	
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	N30	Patient ineligible for this service.	1928	Services not covered while institutionalized - Inpatient services only	3
267	Claim/service spans multiple months.	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	2033	Nursing Home claim spans multiple months.	2
272	Coverage/program guidelines were not met.	N20	Service not payable with other service rendered on the same date.	1837	Invalid procedure code combination.	3

273	Coverage/program guidelines were exceeded.	N640	Exceeds number/frequency approved/allowed within time period.	5507	Crown - Exceeds limit of 1 crown per tooth.	3
282	The procedure/revenue code is inconsistent with the type of bill.	MA30	Missing/incomplete/invalid type of bill.	1979	Invalid revenue or HCPCS code for ESRD	3
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	M62	Missing/incomplete/invalid treatment authorization code.	5047	Missing/invalid GASSP prior authorization	2
				5048	Invalid prior authorization (CMC, JJS, MRB)	
				5543	Invalid/missing prior authorization for an Inpatient psychiatric services	
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	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.	1122	Prior authorization Provider mismatch	2
299	The billing provider is not eligible to receive payment for the service billed.	N767	The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	5313	Provider was voluntarily terminated	3
				5314	Provider is deceased	
299	The billing provider is not eligible to receive payment for the service billed.	N831	You have not responded to requests to revalidate your provider/supplier enrollment information.	1369	Provider Enrollment Stop Payment	3
A1	Claim/Service denied.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	1956	End date of service is outside the range of the OCE editor (OCE edit 0024)	-
A1	Claim/Service denied.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	5358	Crossover claim Inpatient/Outpatient overlap	-
A1	Claim/Service denied.	N47	Claim conflicts with another inpatient stay.	5348	Outpatient services 3 days prior to admit are part of DRG payment	-
A1	Claim/Service denied.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	5366	Unable to price Outpatient claim	-
A8	Ungroupable DRG			1380	DRG not on file	2
A8	Ungroupable DRG			1986	Date of service is after expiration date of current grouper tape	2
A8	Ungroupable DRG	N647	Adjusted based on diagnosis-related group (DRG).	1848	DRG claim has maternity diagnosis and nursery charges	2
B1	Non-covered visits.	N113	Only one initial visit is covered per physician, group practice or provider.	5331	Initial dental exam - Exceeds limit of 1 per lifetime	3
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	1838	Invalid Claim Type for Hospice.	3
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570	Missing/incomplete/invalid credentialing data.	20159	Provider ineligible on date of service	3
				5546	Service is limited to specific providers	
B9	Patient is enrolled in a Hospice.			1966	Hospice Conflict to Hospital claim or Professional invoice	3
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.	1907	Admission date conflict	3
				1920	Possible duplicate - Crossover claim vs Medicaid FFS claim	
				1227	Possible duplicate	
				5343	Possible claim conflict	
				1908	Nursing home to Inpatient possible claim conflict	
				5337	Physician visit - Exceeds limit of 1 per day	
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	M51	Missing/incomplete/invalid procedure code(s).	1945	Missing procedure codes for RHC/FQHC encounter	3
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N122	Add-on code cannot be billed by itself.	2014	Claim lacks required primary code (OCE Edit)	3
B16	New Patient' qualifications were not met.	M86	Service denied because payment already made for same/similar procedure within set time frame.	5355	Not a new patient. Cognitive service within 3 years	3
B16	New Patient' qualifications were not met.	N113	Only one initial visit is covered per physician, group practice or provider.	5368	Not new patient. Same specialty in group	3
B20	Procedure/service was partially or fully furnished by another provider.			1844	Service performed by co-surgeons	3
				1839	Service possibly performed by co-surgeons	

B20	Procedure/service was partially or fully furnished by another provider.	**M86**	Service denied because payment already made for same/similar procedure within set time frame.	**5508**	Pediatric/Neonatal critical care claim conflict - different provider	3
B20	Procedure/service was partially or fully furnished by another provider.	**N538**	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	**5324**	Duplicate ancillary services performed in a Nursing Home	3