Adjustment_Reason_Code	Date_Eff	Date_End	Adjustment_Reason_Desc
1	1/1/1995	12/31/2299	Deductible Amount
2	1/1/1995	12/31/2299	Coinsurance Amount
3	1/1/1995	12/31/2299	Co-payment Amount
4	1/1/1995	12/31/2299	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
5	1/1/1995	12/31/2299	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	1/1/1995	12/31/2299	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
7	1/1/1995	12/31/2299	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
8	1/1/1995	12/31/2299	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
9	1/1/1995	12/31/2299	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
10	1/1/1995	12/31/2299	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
11	1/1/1995	12/31/2299	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
12	1/1/1995	12/31/2299	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
13	1/1/1995	12/31/2299	The date of death precedes the date of service.
14	1/1/1995	12/31/2299	The date of birth follows the date of service.
15	1/1/1995	5/1/2018	The authorization number is missing, invalid, or does not apply to the billed services or provider.

16	1/1/1995	12/31/2299	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
18	1/1/1995	12/31/2299	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
19	1/1/1995	12/31/2299	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	1/1/1995	12/31/2299	This injury/illness is covered by the liability carrier.
21	1/1/1995	12/31/2299	This injury/illness is the liability of the no-fault carrier.
22	1/1/1995	12/31/2299	This care may be covered by another payer per coordination of benefits.
23	1/1/1995	12/31/2299	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	1/1/1995	12/31/2299	Charges are covered under a capitation agreement/managed care plan.
26	1/1/1995	12/31/2299	Expenses incurred prior to coverage.
27	1/1/1995	12/31/2299	Expenses incurred after coverage terminated.
29	1/1/1995	12/31/2299	The time limit for filing has expired.
31	1/1/1995	12/31/2299	Patient cannot be identified as our insured.
32	1/1/1995	12/31/2299	Our records indicate the patient is not an eligible dependent.
33	1/1/1995	12/31/2299	Insured has no dependent coverage.
34	1/1/1995	12/31/2299	Insured has no coverage for newborns.
35	1/1/1995	12/31/2299	Lifetime benefit maximum has been reached.
39	1/1/1995	12/31/2299	Services denied at the time authorization/pre-certification was requested.
40	1/1/1995	12/31/2299	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
44	1/1/1995	12/31/2299	Prompt-pay discount.
45	1/1/1995	12/31/2299	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

49	1/1/1995	12/31/2299	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
50	1/1/1995	12/31/2299	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
51	1/1/1995	12/31/2299	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
53	1/1/1995	12/31/2299	Services by an immediate relative or a member of the same household are not covered.
54	1/1/1995	12/31/2299	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
55	1/1/1995	12/31/2299	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
56	1/1/1995	12/31/2299	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
58	1/1/1995	12/31/2299	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
59	1/1/1995	12/31/2299	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
60	1/1/1995	12/31/2299	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	1/1/1995	12/31/2299	Adjusted for failure to obtain second surgical opinion
66	1/1/1995	12/31/2299	Blood Deductible.
69	1/1/1995	12/31/2299	Day outlier amount.
70	1/1/1995	12/31/2299	Cost outlier - Adjustment to compensate for additional costs.
74	1/1/1995	12/31/2299	Indirect Medical Education Adjustment.

75	1/1/1995	12/31/2299	Direct Medical Education Adjustment.
76	1/1/1995	12/31/2299	Disproportionate Share Adjustment.
78	1/1/1995	12/31/2299	Non-Covered days/Room charge adjustment.
85	1/1/1995	12/31/2299	Patient Interest Adjustment (Use Only Group code PR)
89	1/1/1995	12/31/2299	Professional fees removed from charges.
90	1/1/1995	12/31/2299	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.
91	1/1/1995	12/31/2299	Dispensing fee adjustment.
94	1/1/1995	12/31/2299	Processed in Excess of charges.
95	1/1/1995	12/31/2299	Plan procedures not followed.
96	1/1/1995	12/31/2299	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
97	1/1/1995	12/31/2299	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
100	1/1/1995	12/31/2299	Payment made to patient/insured/responsible party.
101	1/1/1995	12/31/2299	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	1/1/1995	12/31/2299	Major Medical Adjustment.
103	1/1/1995	12/31/2299	Provider promotional discount (e.g., Senior citizen discount).
104	1/1/1995	12/31/2299	Managed care withholding.
105	1/1/1995	12/31/2299	Tax withholding.
106	1/1/1995	12/31/2299	Patient payment option/election not in effect.
107	1/1/1995	12/31/2299	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
108	1/1/1995	12/31/2299	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
109	1/1/1995	12/31/2299	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	1/1/1995	12/31/2299	Billing date predates service date.
111	1/1/1995	12/31/2299	Not covered unless the provider accepts assignment.
112	1/1/1995	12/31/2299	Service not furnished directly to the patient and/or not documented.
114	1/1/1995	12/31/2299	Procedure/product not approved by the Food and Drug Administration.
115	1/1/1995	12/31/2299	Procedure postponed, canceled, or delayed.

116	1/1/1995	12/31/2299	The advance indemnification notice signed by the patient did not comply with requirements.
117	1/1/1995	12/31/2299	Transportation is only covered to the closest facility that can provide the necessary care.
118	1/1/1995	12/31/2299	ESRD network support adjustment.
119	1/1/1995	12/31/2299	Benefit maximum for this time period or occurrence has been reached.
121	1/1/1995	12/31/2299	Indemnification adjustment - compensation for outstanding member responsibility.
122	1/1/1995	12/31/2299	Psychiatric reduction.
128	2/28/1997	12/31/2299	Newborn's services are covered in the mother's Allowance.
129	2/28/1997	12/31/2299	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
130	2/28/1997	12/31/2299	Claim submission fee.
131	2/28/1997	12/31/2299	Claim specific negotiated discount.
132	2/28/1997	12/31/2299	Prearranged demonstration project adjustment.
133	7/1/2014	12/31/2299	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
134	#########	12/31/2299	Technical fees removed from charges.
135	#########	12/31/2299	Interim bills cannot be processed.
136	#########	12/31/2299	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)
137	2/28/1999	12/31/2299	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	6/30/1999	5/1/2018	Appeal procedures not followed or time limits not met.
139	6/30/1999	12/31/2299	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.
140	6/30/1999	12/31/2299	Patient/Insured health identification number and name do not match.
142	6/30/2000	12/31/2299	Monthly Medicaid patient liability amount.
143	2/28/2001	12/31/2299	Portion of payment deferred.
144	6/30/2001	12/31/2299	Incentive adjustment, e.g. preferred product/service.
146	6/30/2002	12/31/2299	Diagnosis was invalid for the date(s) of service reported.
147	6/30/2002	12/31/2299	Provider contracted/negotiated rate expired or not on file.
148	6/30/2002	12/31/2299	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
149	#########	12/31/2299	Lifetime benefit maximum has been reached for this service/benefit category.

150	#########	12/31/2299	Payer deems the information submitted does not support this level of service.
151	#########	12/31/2299	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	#########	12/31/2299	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
153	#########	12/31/2299	Payer deems the information submitted does not support this dosage.
154	#########	12/31/2299	Payer deems the information submitted does not support this day's supply.
155	6/30/2003	12/31/2299	Patient refused the service/procedure.
157	9/30/2003	12/31/2299	Service/procedure was provided as a result of an act of war.
158	9/30/2003	12/31/2299	Service/procedure was provided outside of the United States.
159	9/30/2003	12/31/2299	Service/procedure was provided as a result of terrorism.
160	9/30/2003	12/31/2299	Injury/illness was the result of an activity that is a benefit exclusion.
161	2/29/2004	12/31/2299	Provider performance bonus
163	6/30/2004	12/31/2299	Attachment/other documentation referenced on the claim was not received.
164	6/30/2004	12/31/2299	Attachment/other documentation referenced on the claim was not received in a timely fashion.
165	#########	5/1/2018	Referral absent or exceeded.
166	2/28/2005	12/31/2299	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	6/30/2005	12/31/2299	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
168	6/30/2005	5/1/2018	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	6/30/2005	12/31/2299	Alternate benefit has been provided.
170	6/30/2005	12/31/2299	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
171	6/30/2005	12/31/2299	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
172	6/30/2005	12/31/2299	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

173	6/30/2005	12/31/2299	Service/equipment was not prescribed by a physician.
174	6/30/2005	12/31/2299	Service was not prescribed prior to delivery.
175	6/30/2005	12/31/2299	Prescription is incomplete.
176	6/30/2005	12/31/2299	Prescription is not current.
177	6/30/2005	12/31/2299	Patient has not met the required eligibility requirements.
178	6/30/2005	12/31/2299	Patient has not met the required spend down requirements.
179	6/30/2005	12/31/2299	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
180	6/30/2005	12/31/2299	Patient has not met the required residency requirements.
181	6/30/2005	12/31/2299	Procedure code was invalid on the date of service.
182	6/30/2005	12/31/2299	Procedure modifier was invalid on the date of service.
183	6/30/2005	12/31/2299	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
184	6/30/2005	12/31/2299	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
185	6/30/2005	12/31/2299	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
186	6/30/2005	12/31/2299	Level of care change adjustment.
187	6/30/2005	12/31/2299	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
188	6/30/2005	12/31/2299	This product/procedure is only covered when used according to FDA recommendations.
189	6/30/2005	12/31/2299	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
190	#########	12/31/2299	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
192	#########	12/31/2299	Non standard adjustment code from paper remittance. Usage: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
193	2/28/2006	12/31/2299	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

194	2/28/2006	12/31/2299	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	2/28/2006	12/31/2299	Refund issued to an erroneous priority payer for this claim/service.
197	#########	12/31/2299	Precertification/authorization/notification/pre-treatment absent.
198	#########	12/31/2299	Precertification/notification/authorization/pre-treatment exceeded.
199	#########	12/31/2299	Revenue code and Procedure code do not match.
200	#########	12/31/2299	Expenses incurred during lapse in coverage
201	#########	12/31/2299	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
202	2/28/2007	12/31/2299	Non-covered personal comfort or convenience services.
203	2/28/2007	12/31/2299	Discontinued or reduced service.
204	2/28/2007	12/31/2299	This service/equipment/drug is not covered under the patient's current benefit plan
205	7/9/2007	12/31/2299	Pharmacy discount card processing fee
206	7/9/2007	12/31/2299	National Provider Identifier - missing.
207	7/9/2007	12/31/2299	National Provider identifier - Invalid format
208	7/9/2007	12/31/2299	National Provider Identifier - Not matched.
209	7/9/2007	12/31/2299	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
210	7/9/2007	12/31/2299	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	7/9/2007	12/31/2299	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	11/5/2007	12/31/2299	Administrative surcharges are not covered
213	1/27/2008	12/31/2299	Non-compliance with the physician self referral prohibition legislation or payer policy.
215	1/27/2008	12/31/2299	Based on subrogation of a third party settlement
216	1/27/2008	12/31/2299	Based on the findings of a review organization
219	1/27/2008	12/31/2299	Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

222	6/1/2008	12/31/2299	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
223	6/1/2008	12/31/2299	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	6/1/2008	12/31/2299	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
225	6/1/2008	12/31/2299	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
226	9/21/2008	12/31/2299	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
227	9/21/2008	12/31/2299	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
228	9/21/2008	12/31/2299	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
229	1/25/2009	12/31/2299	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Usage: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)
231	7/1/2009	12/31/2299	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
232	11/1/2009	12/31/2299	Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.
233	1/24/2010	12/31/2299	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.

234	1/24/2010	12/31/2299	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
235	6/6/2010	12/31/2299	Sales Tax
236	1/30/2011	12/31/2299	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
237	6/5/2011	12/31/2299	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
238	3/1/2012	12/31/2299	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
239	3/1/2012	12/31/2299	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	6/3/2012	12/31/2299	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
241	6/3/2012	12/31/2299	Low Income Subsidy (LIS) Co-payment Amount
242	6/3/2012	12/31/2299	Services not provided by network/primary care providers.
243	6/3/2012	12/31/2299	Services not authorized by network/primary care providers.
245	9/30/2012	12/31/2299	Provider performance program withhold.
246	9/30/2012	12/31/2299	This non-payable code is for required reporting only.
247	9/30/2012	12/31/2299	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	9/30/2012	12/31/2299	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	9/30/2012	12/31/2299	This claim has been identified as a readmission. (Use only with Group Code CO)
250	9/30/2012	12/31/2299	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
251	9/30/2012	12/31/2299	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

252	9/30/2012	12/31/2299	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
253	6/2/2013	12/31/2299	Sequestration - reduction in federal payment
254	6/2/2013	12/31/2299	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
256	6/2/2013	12/31/2299	Service not payable per managed care contract.
257	11/1/2013	12/31/2299	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)
258	11/1/2013	12/31/2299	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	1/26/2014	12/31/2299	Additional payment for Dental/Vision service utilization.
260	1/26/2014	12/31/2299	Processed under Medicaid ACA Enhanced Fee Schedule
261	6/1/2014	12/31/2299	The procedure or service is inconsistent with the patient's history.
262	11/1/2014	12/31/2299	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.
263	11/1/2014	12/31/2299	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.
264	11/1/2014	12/31/2299	Adjustment for postage cost. Usage: To be used for pharmaceuticals only.
265	11/1/2014	12/31/2299	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.
266	11/1/2014	12/31/2299	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.
267	11/1/2014	12/31/2299	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
268	11/1/2014	12/31/2299	The Claim spans two calendar years. Please resubmit one claim per calendar year.
269	3/1/2015	12/31/2299	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
270	7/1/2015	12/31/2299	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.

271	11/1/2015	12/31/2299	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)
272	11/1/2015	12/31/2299	Coverage/program guidelines were not met.
273	11/1/2015	12/31/2299	Coverage/program guidelines were exceeded.
274	11/1/2015	12/31/2299	Fee/Service not payable per patient Care Coordination arrangement.
275	11/1/2015	12/31/2299	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
276	11/1/2015	12/31/2299	Services denied by the prior payer(s) are not covered by this payer.
277	11/1/2015	12/31/2299	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)
278	7/1/2016	12/31/2299	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
279	11/1/2016	12/31/2299	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.
280	3/1/2017	12/31/2299	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
281	7/1/2017	12/31/2299	Deductible waived per contractual agreement. Use only with Group Code CO.
282	7/1/2017	12/31/2299	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
283	11/1/2017	12/31/2299	Attending provider is not eligible to provide direction of care.
284	11/1/2017	12/31/2299	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
285	11/1/2017	12/31/2299	Appeal procedures not followed
286	11/1/2017	12/31/2299	Appeal time limits not met
287	11/1/2017	12/31/2299	Referral exceeded
288	11/1/2017	12/31/2299	Referral absent
289	11/1/2017	12/31/2299	Services considered under the dental and medical plans, benefits not available.

290	11/1/2017	12/31/2299	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.
291	11/1/2017	12/31/2299	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.
292	11/1/2017	12/31/2299	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.
293	5/1/2018	12/31/2299	Payment made to employer.
294	11/1/2017	12/31/2299	Payment made to attorney.
295	3/1/2018	12/31/2299	Pharmacy Direct/Indirect Remuneration (DIR)
296	7/1/2018	12/31/2299	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
A0	1/1/1995	12/31/2299	Patient refund amount.
A1	1/1/1995	12/31/2299	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
A5	1/1/1995	12/31/2299	Medicare Claim PPS Capital Cost Outlier Amount.
A6	1/1/1995	12/31/2299	Prior hospitalization or 30 day transfer requirement not met.
A8	1/1/1995	12/31/2299	Ungroupable DRG.
B1	1/1/1995	12/31/2299	Non-covered visits.
B10	1/1/1995	12/31/2299	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	1/1/1995	12/31/2299	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	1/1/1995	12/31/2299	Services not documented in patient's medical records.
B13	1/1/1995	12/31/2299	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	1/1/1995	12/31/2299	Only one visit or consultation per physician per day is covered.
B15	1/1/1995	12/31/2299	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B16	1/1/1995	12/31/2299	'New Patient' qualifications were not met.
B20	1/1/1995	12/31/2299	Procedure/service was partially or fully furnished by another provider.
B22	1/1/1995	12/31/2299	This payment is adjusted based on the diagnosis.

B23	1/1/1995	12/31/2299	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
B4	1/1/1995	12/31/2299	Late filing penalty.
B7	1/1/1995	12/31/2299	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B8	1/1/1995	12/31/2299	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B9	1/1/1995	12/31/2299	Patient is enrolled in a Hospice.
P1	11/1/2013	12/31/2299	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P10	11/1/2013	12/31/2299	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.
P11	11/1/2013	12/31/2299	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)
P12	11/1/2013	12/31/2299	Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
P13	11/1/2013	12/31/2299	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.

P14	11/1/2013	12/31/2299	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.
P15	11/1/2013	12/31/2299	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.
P16	11/1/2013	12/31/2299	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)
P17	11/1/2013	12/31/2299	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.
P18	11/1/2013	12/31/2299	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.
P19	11/1/2013	12/31/2299	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.
P2	11/1/2013	12/31/2299	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.
P20	11/1/2013	12/31/2299	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.
P21	11/1/2013	12/31/2299	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.

P22	11/1/2013	12/31/2299	Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P23	11/1/2013	12/31/2299	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P24	11/1/2017	12/31/2299	Payment adjusted based on Preferred Provider Organization (PPO). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. Use only with Group Code CO.
P25	11/1/2017	12/31/2299	Payment adjusted based on Medical Provider Network (MPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).

P26	11/1/2017	12/31/2299	Payment adjusted based on Voluntary Provider network (VPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty only. (Use only with Group Code CO).
P27	11/1/2017	12/31/2299	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P28	11/1/2017	12/31/2299	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P29	11/1/2017	12/31/2299	Liability Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P3	11/1/2013	12/31/2299	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)

P4	11/1/2013	12/31/2299	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
P5	11/1/2013	12/31/2299	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.
P6	11/1/2013	12/31/2299	Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.
P7	11/1/2013	12/31/2299	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.
P8	11/1/2013	12/31/2299	Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.
P9	11/1/2013	12/31/2299	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.
DCS - MRO location not covered	NULL	12/31/2299	MRO location not covered
DCS - Not a Provider for Patient Med Type	NULL	12/31/2299	Not a Provider for Patient Med Type
DCS -CFTM/Case Conference	NULL	12/31/2299	CFTM/Case Conference
DCS -Collateral Contact	NULL	12/31/2299	Collateral Contact
DCS -Report Writing	NULL	12/31/2299	Report Writing

DCS -SASSI	NULL	12/31/2299	SASSI
DCS -Service not Medicaid eligible	NULL	12/31/2299	Service not Medicaid eligible
DCS -Skills Training	NULL	12/31/2299	Skills Training
DCS-DCS/Prob OR Court Medical Reqs not met	NULL	12/31/2299	DCS/Probation-requested OR court-ordered service does not meet requirements for medical necessity
DCS-LON does not meet requirements	9/4/2020	12/31/2299	Level of Need does not meet requirements
DCS-Medicaid minimum time for CS Svs not met	NULL	12/31/2299	Service does not meet Medicaid minimum time requirements, i.e., 16 minutes for individual services; 26 minutes for family services
DCS-Transportation	NULL	12/31/2299	Transportation