

Claim Adjustment Reason Codes

Group Code Definitions

The Group Code is combined with the Claim Adjustment Reason Code to demonstrate who has financial responsibility for the amount. They are:

PR - Patient Responsibility. This shows what amount the beneficiary or his/her supplemental insurer is responsible for. **PR** amounts, including the deductible and coinsurance, are totaled in the Patient Responsibility field at the end of each claim. If you already collected an amount from a beneficiary for this claim in excess of the Patient Responsibility total prior to receipt of the remittance notice, you are required by law to refund that excess to the beneficiary.

CO - Contractual Obligation. **CO** is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial liability, such as participation agreement violation amounts, limiting charge violations, late filing penalties, or amounts for services not considered to be reasonable and necessary. You may not hold a beneficiary financially responsible for any adjustments identified with this group code.

OA - Other Adjustment. Used when neither **PR** nor **CO** applies, such as with the reason code message that indicates the bill is being paid in full.

CR - Correction to or Reversal of a prior decision. Demonstrates when there is a change to the decision on a previously adjudicated claim, perhaps as result of a subsequent reopening. **CR** explains the reason for a change and is always used with **PR**, **CO**, or **OA** to show revised information.

1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age. <i>Note: Changed as of 6/02</i>
7	The procedure/revenue code is inconsistent with the patient's gender. <i>Note: Changed as of 6/02</i>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). <i>Note: Changed as of 6/02</i>
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender. <i>Note: Changed as of 2/00</i>
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. <i>Note: Changed as of 2/01</i>
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate <i>Note: Changed as of 2/02</i>
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. <i>Note: Changed as of 2/02</i>

18 Duplicate claim/service.

19 Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 Claim denied because this injury/illness is covered by the liability carrier.

21 Claim denied because this injury/illness is the liability of the no-fault carrier.

22 Payment adjusted because this care may be covered by another payer per coordination of benefits.
Note: Changed as of 2/01

23 Payment adjusted because charges have been paid by another payer.
Note: Changed as of 2/01

24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
Note: Changed as of 6/00

25 Payment denied. Your Stop loss deductible has not been met.

26 Expenses incurred prior to coverage.

27 Expenses incurred after coverage terminated.

28 Coverage not in effect at the time the service was provided.
Note: Inactive for 004010, since 6/98. Redundant to codes 26&27.

29 The time limit for filing has expired.

30 Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
Note: Changed as of 2/01

31 Claim denied as patient cannot be identified as our insured.

32 Our records indicate that this dependent is not an eligible dependent as defined.

33 Claim denied. Insured has no dependent coverage.

34 Claim denied. Insured has no coverage for newborns.

35 Lifetime benefit maximum has been reached.
Note: Changed as of 10/02

36 Balance does not exceed co-payment amount.
Note: Inactive for 003040

37 Balance does not exceed deductible.
Note: Inactive for 003040

38 Services not provided or authorized by designated (network/primary care) providers.
Note: Changed as of 6/03

39 Services denied at the time authorization/pre-certification was requested.

40 Charges do not meet qualifications for emergent/urgent care.

41 Discount agreed to in Preferred Provider contract.
Note: Inactive for 003040

42 Charges exceed our fee schedule or maximum allowable amount.

43 Gramm-Rudman reduction.

44 Prompt-pay discount.

45 Charges exceed your contracted/ legislated fee arrangement.

46 This (these) service(s) is (are) not covered.
Note: Inactive for 004010, since 6/00. Use code 96.

47 This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
Note: Changed as of 6/00

48 This (these) procedure(s) is (are) not covered.
Note: Inactive for 004010, since 6/00. Use code 96.

49 These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 These are non-covered services because this is a pre-existing condition.

52 The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
Note: Changed as of 10/98

53 Services by an immediate relative or a member of the same household are not covered.

54 Multiple physicians/assistants are not covered in this case .

55 Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.

57 Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
Note: Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.

58 Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
Note: Changed as of 2/01

59 Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
Note: Changed as of 6/00

60 Charges for outpatient services with this proximity to inpatient services are not covered.

61 Charges adjusted as penalty for failure to obtain second surgical opinion.
Note: Changed as of 6/00

62 Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
Note: Changed as of 2/01

63 Correction to a prior claim.
Note: Inactive for 003040

64 Denial reversed per Medical Review.
Note: Inactive for 003040

65 Procedure code was incorrect. This payment reflects the correct code.
Note: Inactive for 003040

66 Blood Deductible.

67 Lifetime reserve days. (Handled in QTY, QTY01=LA)
Note: Inactive for 003040

68 DRG weight. (Handled in CLP12)
Note: Inactive for 003040

69 Day outlier amount.

70 Cost outlier - Adjustment to compensate for additional costs.
Note: Changed as of 6/01

71 Primary Payer amount.
Note: Deleted as of 6/00. Use code 23.

72 Coinsurance day. (Handled in QTY, QTY01=CD)
Note: Inactive for 003040

73 Administrative days.
Note: Inactive for 003050

74 Indirect Medical Education Adjustment.

75 Direct Medical Education Adjustment.

76 Disproportionate Share Adjustment.

77 Covered days. (Handled in QTY, QTY01=CA)
Note: Inactive for 003040

78 Non-Covered days/Room charge adjustment.

79 Cost Report days. (Handled in MIA15)
Note: Inactive for 003050

80 Outlier days. (Handled in QTY, QTY01=OU)
Note: Inactive for 003050

81 Discharges.
Note: Inactive for 003040

- 82 PIP days.
Note: Inactive for 003040
- 83 Total visits.
Note: Inactive for 003040
- 84 Capital Adjustment. (Handled in MIA)
Note: Inactive for 003050
- 85 Interest amount.
- 86 Statutory Adjustment.
Note: Inactive for 004010, since 6/98. Duplicative of code 45.
- 87 Transfer amount.
- 88 Adjustment amount represents collection against receivable created in prior overpayment.
Note: Inactive for 004050.
- 89 Professional fees removed from charges.
- 90 Ingredient cost adjustment.
- 91 Dispensing fee adjustment.
- 92 Claim Paid in full.
Note: Inactive for 003040
- 93 No Claim level Adjustments.
Note: Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.
- 94 Processed in Excess of charges.
- 95 Benefits adjusted. Plan procedures not followed.
Note: Changed as of 6/00
- 96 Non-covered charge(s).
- 97 Payment is included in the allowance for another service/procedure.
Note: Changed as of 2/99
- 98 The hospital must file the Medicare claim for this inpatient non-physician service.
Note: Inactive for 003040
- 99 Medicare Secondary Payer Adjustment Amount.
Note: Inactive for 003040
- 100 Payment made to patient/insured/responsible party.
- 101 Predetermination: anticipated payment upon completion of services or claim adjudication.
Note: Changed as of 2/99
- 102 Major Medical Adjustment.
- 103 Provider promotional discount (e.g., Senior citizen discount).
Note: Changed as of 6/01
- 104 Managed care withholding.
- 105 Tax withholding.
- 106 Patient payment option/election not in effect.
- 107 Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
Note: Changed as of 6/03
- 108 Payment adjusted because rent/purchase guidelines were not met.
Note: Changed as of 6/02
- 109 Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 110 Billing date predates service date.
- 111 Not covered unless the provider accepts assignment.
- 112 Payment adjusted as not furnished directly to the patient and/or not documented.
Note: Changed as of 2/01
- 113 Payment denied because service/procedure was provided outside the United States or as a result of war.
Note: Changed as of 2/01; Inactive for version 004060. Use Codes 157, 158 or 159.
- 114 Procedure/product not approved by the Food and Drug Administration.

- 115** Payment adjusted as procedure postponed or canceled.
Note: Changed as of 2/01
- 116** Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
Note: Changed as of 2/01
- 117** Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
Note: Changed as of 2/01
- 118** Charges reduced for ESRD network support.
- 119** Benefit maximum for this time period or occurrence has been reached.
Note: Changed as of 2/04
- 120** Patient is covered by a managed care plan.
Note: Inactive for 004030, since 6/99. Use code 24.
- 121** Indemnification adjustment.
- 122** Psychiatric reduction.
- 123** Payer refund due to overpayment.
Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
- 124** Payer refund amount - not our patient.
Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
- 125** Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
Note: Changed as of 2/02
- 126** Deductible -- Major Medical
Note: New as of 2/97
- 127** Coinsurance -- Major Medical
Note: New as of 2/97
- 128** Newborn's services are covered in the mother's Allowance.
Note: New as of 2/97
- 129** Payment denied - Prior processing information appears incorrect.
Note: Changed as of 2/01
- 130** Claim submission fee.
Note: Changed as of 6/01
- 131** Claim specific negotiated discount.
Note: New as of 2/97
- 132** Prearranged demonstration project adjustment.
Note: New as of 2/97
- 133** The disposition of this claim/service is pending further review.
Note: Changed as of 10/99
- 134** Technical fees removed from charges.
Note: New as of 10/98
- 135** Claim denied. Interim bills cannot be processed.
Note: New as of 10/98
- 136** Claim Adjusted. Plan procedures of a prior payer were not followed.
Note: Changed as of 6/00
- 137** Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
Note: New as of 2/99
- 138** Claim/service denied. Appeal procedures not followed or time limits not met.
Note: New as of 6/99
- 139** Contracted funding agreement - Subscriber is employed by the provider of services.
Note: New as of 6/99
- 140** Patient/Insured health identification number and name do not match.
Note: New as of 6/99
- 141** Claim adjustment because the claim spans eligible and ineligible periods of coverage.
Note: Changed as of 6/00

- 142** Claim adjusted by the monthly Medicaid patient liability amount.
Note: New as of 6/00
- 143** Portion of payment deferred. *Note: New as of 2/01*
- 144** Incentive adjustment, e.g. preferred product/service.
Note: New as of 6/01
- 145** Premium payment withholding
Note: New as of 6/02
- 146** Payment denied because the diagnosis was invalid for the date(s) of service reported.
Note: New as of 6/02
- 147** Provider contracted/negotiated rate expired or not on file.
Note: New as of 6/02
- 148** Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
Note: New as of 6/02
- 149** Lifetime benefit maximum has been reached for this service/benefit category.
Note: New as of 10/02
- 150** Payment adjusted because the payer deems the information submitted does not support this level of service.
Note: New as of 10/02
- 151** Payment adjusted because the payer deems the information submitted does not support this many services.
Note: New as of 10/02
- 152** Payment adjusted because the payer deems the information submitted does not support this length of service.
Note: New as of 10/02
- 153** Payment adjusted because the payer deems the information submitted does not support this dosage.
Note: New as of 10/02
- 154** Payment adjusted because the payer deems the information submitted does not support this day's supply.
Note: New as of 10/02
- 155** This claim is denied because the patient refused the service/procedure.
Note: New as of 6/03
- 156** Flexible spending account payments
Note: New as of 9/03
- 157** Payment denied/reduced because service/procedure was provided as a result of an act of war.
Note: New as of 9/03
- 158** Payment denied/reduced because the service/procedure was provided outside of the United States.
Note: New as of 9/03
- 159** Payment denied/reduced because the service/procedure was provided as a result of terrorism.
Note: New as of 9/03
- 160** Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
Note: New as of 9/03
- 161** Provider performance bonus
Note: New as of 2/04
- 162** State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
Note: New as of 2/04
- 163** Claim/Service adjusted because the attachment referenced on the claim was not received.
Note: New as of 6/04
- 164** Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
Note: New as of 6/04
- A0** Patient refund amount.
- A1** Claim denied charges.
- A2** Contractual adjustment.
Note: Inactive for version 004060. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
- A3** Medicare Secondary Payer liability met

Note: Inactive for 004010, since 6/98.

- A4** Medicare Claim PPS Capital Day Outlier Amount.
- A5** Medicare Claim PPS Capital Cost Outlier Amount.
- A6** Prior hospitalization or 30 day transfer requirement not met.
- A7** Presumptive Payment Adjustment
Note:
- A8** Claim denied; ungroupable DRG
- B1** Non-covered visits.
Note:
- B2** Covered visits.
Note: Inactive for 003040
- B3** Covered charges.
Note: Inactive for 003040
- B4** Late filing penalty.
- B5** Payment adjusted because coverage/program guidelines were not met or were exceeded.
Note: Changed as of 2/01
- B6** This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
Note: Changed as of 2/01
- B7** This provider was not certified/eligible to be paid for this procedure/service on this date of service.
Note: Changed as of 10/98
- B8** Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9** Services not covered because the patient is enrolled in a Hospice.
- B10** Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
Note:
- B11** The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
Note:
- B12** Services not documented in patients' medical records.
Note:
- B13** Previously paid. Payment for this claim/service may have been provided in a previous payment.
Note:
- B14** Payment denied because only one visit or consultation per physician per day is covered.
Note: Changed as of 2/01
- B15** Payment adjusted because this procedure/service is not paid separately.
Note: Changed as of 2/01
- B16** Payment adjusted because `New Patient' qualifications were not met.
Note: Changed as of 2/01
- B17** Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
Note: Changed as of 2/01
- B18** Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
Note: Changed as of 2/01
- B19** Claim/service adjusted because of the finding of a Review Organization.
Note: Inactive for 003070
- B20** Payment adjusted because procedure/service was partially or fully furnished by another provider.
Note: Changed as of 2/01
- B21** The charges were reduced because the service/care was partially furnished by another physician.
Note: Inactive for 003040
- B22** This payment is adjusted based on the diagnosis.
Note: Changed as of 2/01

B23 Payment denied because this provider has failed an aspect of a proficiency testing program.
Note: Changed as of 2/01

D1 Claim/service denied. Level of subluxation is missing or inadequate.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D2 Claim lacks the name, strength, or dosage of the drug furnished.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D4 Claim/service does not indicate the period of time for which this will be needed.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D5 Claim/service denied. Claim lacks individual lab codes included in the test.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D6 Claim/service denied. Claim did not include patient's medical record for the service.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D7 Claim/service denied. Claim lacks date of patient's most recent physician visit.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D8 Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.

D10 Claim/service denied. Completed physician financial relationship form not on file.
Note: Inactive for 003070, since 8/97. Use code 17.

D11 Claim lacks completed pacemaker registration form.
Note: Inactive for 003070, since 8/97. Use code 17.

D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
Note: Inactive for 003070, since 8/97. Use code 17.

D13 Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
Note: Inactive for 003070, since 8/97. Use code 17.

D14 Claim lacks indication that plan of treatment is on file.
Note: Inactive for 003070, since 8/97. Use code 17.

D15 Claim lacks indication that service was supervised or evaluated by a physician.
Note: Inactive for 003070, since 8/97. Use code 17.

D16 Claim lacks prior payer payment information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [N4].

D17 Claim/Service has invalid non-covered days.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M32, M33].

D18 Claim/Service has missing diagnosis information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [MA63, MA65].

D19 Claim/Service lacks Physician/Operative or other supporting documentation
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66].

D20 Claim/Service missing service/product information.
Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67].

W1 Workers Compensation State Fee Schedule Adjustment
Note: New as of 2/00

<http://www.wpc-edi.com/codes/Codes.asp>