| CARC # | Descriptor | Is it an appealable denial? | What to do |
| --- | --- | --- | --- |
| 1 | Deductible | No | N/A |
| 2 | Coinsurance Amount | No | N/A |
| 3 | Co-payment Amount | No | N/A |
| 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure code is inconsistent with the modifier used or a required modifier is missing  | Yes | Check the modifier on claim against payer policy. If the payer allows telephonic appeals, use this option to appeal or cancel claim and re-bill with correct modifier or if payer is wrong, appeal. Have appeal reviewed by a Certified Coder. |
| 5 | The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure code/bill type is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | Check the place of service on the claim against where the item or service happened. If the payer is incorrect, try for a telephonic appeal. This is a rare denial code. |
| 6 | The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure/revenue code is inconsistent with the patient's age.  | Yes | Check for typo’s in the patient’s birth date. If wrong, appeal by telephone or re-bill. If the payer is incorrect, call them to see why this edit came up because it is rare in Oncology. |
| 7 | The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure/revenue code is inconsistent with the patient's gender.  | Yes | Check gender and, in hospitals, check revenue codes. If wrong, appeal by telephone or re-bill. If the payer is incorrect, call them to see why this edit came up because it is rare in Oncology, EXCEPT in male breast cancer |
| 8 | The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The procedure code is inconsistent with the provider type/specialty (taxonomy).  | Yes | This may occur if the provider’s specialty is incorrect with the payer OR the provider is not on a specialty panel for a certain types of procedures. Check with payer. Then, rebill or try to correct by telephone. |
| 9 | The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The diagnosis is inconsistent with the patient's age  | Yes | Make sure that the diagnosis is not transposed or incorrect. Then, check the birth date for errors. Cancel claim and re-bill, if errors are found. Call the payer if your data is correct and ascertain reason for this code. |
| 10 | The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The diagnosis is inconsistent with the patient's gender  | Yes | Check the diagnosis and make sure there are no errors. Also, check the patient’s gender for errors. Cancel claim and re-bill, if errors are found. Call the payer if your data is correct and ascertain reason for this code. |
| 11 | The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The diagnosis is inconsistent with the procedure.  | Yes | If this is a typo, you may be able to appeal by phone. Otherwise, appeal claim defending use of this diagnosis. If ‘off-label’, be sure to have compendia or articles of accepted journals to accompany the appeal. Hopefully, the patient also signed an ABN and you registered for drug replacement as applicable. |
| 12 | The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The diagnosis is inconsistent with the provider type.  | Yes | Cancel claim and correct ICD-10 or the physician specialty code. If this is a Nurse Practitioner or PA claim, check that they are registered with the panel for this payer. Appeal if both are correct on the initial claim.  |
| 13 | The date of death precedes the date of service | Yes | All payers disallow billings after the official date of death. If the payer allows telephonic appeals, use this option or cancel claim and re-bill with correct modifier or appeal if payer is wrong |
| 14 | The date of birth follows the date of service | Yes | This is a rare error in Oncology. This is an obvious key punch error. Cancel claim and re-bill using the correct date of birth or service. |
| 15 | The authorization number is missing, invalid or does not apply to billed services. | Yes | Remember that most new oncology treatments, services, or drugs require authorization. Cancel claim and apply valid authorization number, if one exists. If no auth is valid, appeal use of authorization with proof of medical necessity AND apply for patient assistance. Some programs will not cover this. |
| 16 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation  | Yes | This denial code can be turned around by submitting the proper documentation. Read the Remark Code on the claim and take the necessary action to complete billing.  |
| 18 | Duplicate claim/service | No | Stop sending duplicate claims and find out why the claim is not being paid. You can be targeted for an audit with too many duplicate claims. |
| 19 | This is a work-related illness or injury and should be the responsibility of Workers’ Comp | Yes | Check out whether patient has a work related problem. If they do, change the diagnosis and re-bill to the appropriate party. |
| 20 | This illness or injury is covered by the liability insurance | Yes | Check out whether patient has an accident related problem or change the patient’s diagnosis and re-bill to the appropriate party. |
| 21 | This illness or injury is covered by the no-fault insurance | Yes | Check out whether patient has an accident related problem or change the diagnosis and re-bill to the appropriate party. |
| 22 | This care may be covered by another payer per coordination of benefits | Yes | This appears to e an intake problem. Check patient intake to ensure that billed payer is the proper insurance. If not, cancel claim and bill to right payer. If not, appeal claim based on intake information. For Medicare, this is an MSP edit so Medicare thinks someone else should pay for it. |
| 23 | The impact of another payer’s adjudication including payments and/or adjustments (Used only with OA-) | No | The payment is being adjusted based on coordination of benefits. There is nothing to be done. |
| 24 | Charges are covered under a capitation agreement or managed care contract. | No | What you are billing for is covered under a capitation agreement. You, according to this code, do not have a ‘carve out’ for the billed service. Appeal only if contract does not exist or you have a contracted carve out. |
| 26 | Expenses incurred prior to coverage. | Yes | Re-verify first date of coverage. Make sure insurance numbers, dates, and identification numbers are correct on claim and then re-bill if correction is made. If patient is still uninsured, contact employee benefits manager to verify. Lastly, apply for patient assistance, if patient rendered uninsured. |
| 27 | Expenses incurred after coverage terminated. | Yes | Did the patient lose employment since their last visit? Do they now have COBRA that is not accounted for? Make sure insurance numbers, dates, and identification numbers are correct on claim and then re-bill if correction is made. Otherwise, contact employee benefits manager to verify. Lastly, apply for patient assistance, if patient rendered uninsured. |
| 29 | The time limit for filing has expired. | Yes | Make sure that this is true via the contract with the payer and the service date is correct. Medicare’s time limit is one calendar year, exactly 365 days from service.  |
| 31 | The patient cannot be identified as our insured | Yes | Check patient demographics and insurance numbers—with employer if necessary. Correct and re-bill as appropriate or try for a telephone appeal. Check for fraudulent insurance cards next. If no insurance evidenced, apply for patient assistance. |
| 32 | Our records indicate that the dependent was not a dependent as defined. | Yes | Ensure through payer or employer that the dependent was registered as such or that there is dependent coverage. Also check identification for birthdate. Children can have coverage until the December 31st of the year they turned 26. Apply for patient assistance as necessary. |
| 33 | Insured has no dependent coverage. | Yes | Ensure through payer or employer that there is dependent coverage. Under the law, children can use their parents coverage until December 31st the year they become 26. Apply for patient assistance as necessary. |
| 34 | Insured has no coverage for newborns. | Yes | Verify that this is true through insurer or employer. Sometimes can negotiate with obstetrical Carrier to pay for newborn. Apply for assistance as necessary. |
| 35 | Lifetime maximum has been reached. | Yes | Call employer or caregiver to verify lifetime maximum amount and status. Then request a complete audit of patient expenses to verify max has been reached. In the meantime, apply for patient assistance. |
| 39 | Services denied at the time pre-auth or pre-cert was requested. | Yes | Make sure this is not a mistake. This can be appealed with low probability of success, unless misleading or insufficient information was given. The patient is rendered uninsured; apply for patient assistance or make the patient Self-Pay. |
| 40 | Charges do not meet qualifications for urgent/emergent care | Yes | Check the diagnosis code and billing to see why this decision was made. Next, check your contract to see if you can appeal. Re-bill or appeal as necessary. |
| 44 | Prompt pay discount | No | Nothing |
| 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: 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) This change effective September 1, 2017: 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**.**  | No | Make sure this amount is your contracted allowable. If this is a drug without a J-code, make sure this amount matches your contracted rate. |
| 49 | Routine preventive services done in conjunction with a routine exam. | Yes | Check the coding of separate services and ensure that these were preventative and not separately billable. Re-bill or appeal as necessary. |
| 50 | These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: These are non-covered services because this is not deemed a 'medical necessity' by the payer. | Yes | First, check diagnosis codes against payer guidelines. If these are correct, make sure you get clinical information that justifies the decision to use the item or service. Consult State Off-Label Laws as necessary. If the patient signed an Advance Beneficiary Notice, apply for assistance or Drug Replacement as possible. |
| 51 | Non-covered services due a pre-existing condition | Yes | First, this is no longer legal per ACA. Check with employee benefits manager to see if the employer wants to go down this road. Apply for Patient Assistance as necessary and applicable. |
| 53 | Delivery of service by an immediate family member or relative of payer | Yes | Rarely happens, but this should not occur |
| 54 | Multiple physicians/ assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | Usually more than one E/M service per physician or specialist in a day. Can also mean Assistant Surgeon was billed and procedure does not typically require one. Appeal only for extraordinary circumstances. |
| 55 | Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Procedure/treatment/drug is deemed experimental/investigational by the payer.  | Yes | Appeal the case based on compendia coverage, community standard, or other scientific evidence. Make sure a physician or other provider is involved in the appeal. |
| 56 | Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Procedure/treatment has not been deemed 'proven to be effective' by the payer.  | Yes | Find the product information and match it to diagnosis codes. If diagnosis codes are correct, find supporting literature to prove that the product is effective for the diagnosis billed. Appeal. |
| 58 | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. | Yes | Procedure usually done in the hospital was done in the office or vice versa. Make sure the place of service is correct. Not appealable if this is true. |
| 59 | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia).  | Yes | Fluids cannot be given concurrent to IV drugs (Re-bill and use -59, if hydration and/or fluids ARE NOT CONCURRENT). Certain anesthesia cannot be given in some minor procedures. Some imaging cannot be billed together. This could also be true for CCM (Chronic Care Management) codes. Appeal if concurrent procedure was warranted due to unusual care. |
| 60 | Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services. | Yes | Usually this is a denial due to the Medicare 72-hour rule or due to a bundled inpatient procedure. If it is and you are not billing on a UB-04 (CMS-1450), check your payer contract for bundled services. |
| 61 | Penalty for failure to obtain second surgical opinion. | Yes | Make sure the second opinion has been obtained and re-bill. Otherwise, it is no appealable, unless highly emergent surgery. |
| 66 | Blood deductible | No | Three-unit blood deductible in a calendar year from Medicare. Patient or secondary must pay. |
| 69 | Day outlier amount | No | Nothing—it is a payment to hospitals. |
| 70 | Cost outlier adjustment | No | Nothing—it is a payment to hospitals. |
| 74 | Indirect Medical Adjustment | No | Payment for educating House Staff. |
| 75 | Direct Medical Education Adjustment | No | Payment for educating House Staff. |
| 76 | Disproportionate Share Adjustment | No | Payment to DSH hospitals |
| 78 | Non-covered days or room charge | No | Payer is not paying for days in the hospital or outpatient room charge for coverage reasons |
| 85 | Patient interest adjustment | No | Interest charges are the responsibility of the patient. This could be due to past premium delinquency. |
| 89 | Professional fees are removed from payment | No | Only the technical portion is paid as the professional fees have been paid for S&I previously or were not covered. |
| 90 | Ingredient cost adjustment | Yes | Might be for compounded drugs. This also means there was an adjustment in drug pricing because the payer thought there was a comparable drug at a lower price. This is sometimes known as the Least Costly Alternative. Contact the drug company of branded drugs ASAP for this one. |
| 91 | Dispensing fee adjustment | No | Adjustment for a dispensing fee---that’s a good thing! |
| 94 | Processed in excess of charges | No | This could be because the secondary payer is paying zero or less because the combined amount between primary and secondary is in excess of charges. Check your charge schedule and make sure that you are not charging less than what is allowed. |
| 95 | Plan procedures not followed | Yes | Check the claim and make sure your claim fits what the contract or rules call for. Sometimes this is a missing referral number or PCP name, but not always. |
| 96 | 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Non-covered charge(s). At least one Remark Code must be provided  | Yes | Check the remark code and find out why the service is not covered. Is it a contract problem or unbundling? Have you given higher than the labeled dose or more than the recommended cycles? If this is a drug and the patient is rendered uninsured, contact patient assistance. |
| 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.  | Yes | This code can be used for a number of reasons. First, if Medicaid secondary decides that the Medicare primary is more than their allowable they will use it. Also, it is used for unbundling. If you see this for unbundling repeatedly, maybe you should stop charging bundled procedures. Most often, this is a duplicate claim edit. |
| 100 | Payment made to patient/insured/responsible party/employer. | Yes | Are you Non-PAR? Someone else besides the billing entity was paid and you don’t know about it. Make sure you have a contract or assignment agreement with this payer. Also, make efforts to collect. |
| 101 | Predetermination: anticipated payment upon completion of services or claim adjudication. | No | Claim has been submitted for a predetermination/precert and will be paid once the entire service is performed or the claim is finalized. If the service has been completed, call the payer and find out why this denial code was used. |
| 102 | Major Medical Adjustment. | No | An adjustment is being applied to the claim because it falls under the patient’s major medical (as opposed to the pharmacy for example). Unless this amount violates your contract with the payer, do nothing. |
| 103 | Provider promotional discount (e.g., Senior citizen discount). | No | This is rarely used because giving patients discounts is illegal in many states and runs afoul of self-referral laws. Remember courtesy discounts can also be a problem. |
| 104 | Managed Care Withholding | No | Because of a contract you have with a managed care company, a withhold is being taken from the payment. Check your contract or call the plan to ascertain what this represents. |
| 105 | Tax Withholding | No | Tax is being withheld from your claims. Medicare has a coordinated agreement with the IRS if any provider owes Federal Tax. Check with the applicable provider. Might be used for state taxes in your area. |
| 106 | Patient payment option/ election not in effect. | No | Payment was supposed to go to the patient, but they elected for it to go to you. |
| 107 | The related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | The service billed is an ‘add on’ code or service (e.g. a sequential infusion or additional hour). The payer is not seeing the qualifying service on the same day. Sometimes this is their error and it can be corrected by telephone or by re-billing. This denial code can also be applied to drug claims that require other drugs to be given first, e.g. 2nd and 3rd line |
| 108 | Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | This is a DME (Durable Medical Equipment) error. After a certain amount of months, patients must buy their equipment and not rent it. Either the patient must buy their equipment or it is also possible that the wrong modifier was used. Check this and take the action that is appropriate. |
| 109 | Claim not covered by this contractor. | Yes | This is often a Medicare Secondary Payer edit. Is the patient covered by Medicare? The intake information on this claim was sequenced incorrectly (primary should have been sequenced) or the payer thinks they are not the primary payer. Check with your patient and, if this denial code is wrong, appeal it with the correct information. |
| 110 | Billing date pre-dates the service date | Yes | An obvious data entry error. Correct by telephone or cancel claim and re-bill or get corrected by phone if possible. |
| 111 | Not covered unless the provider accepts assignment | Yes | All drug claims require assignment. You must take assignment to get paid by this payer. Call them to ensure you know what the terms are of the contract and whether you are in/out of network. |
| 112 | Service not furnished directly to the patient and/or not documented. | Yes | There is lack of information that this service was provided directly to this patient face-to-face. This code can also be used for non-face-to-face codes like telephone calls, etc. which the payer may not allow. |
| 114 | Procedure/product not approved by the FDA | Yes | Something on the claim made the payer think that the product or indication was not FDA-approved. Make sure that the information on the claim is consistent with FDA approval. Double check diagnosis coding. If the indication is off-label, gather clinical literature and a letter of medical necessity and appeal the claim. Make sure you are aware of your State’s off-label laws. |
| 115 | Procedure postponed, delayed or canceled. | No | The claim was probably billed with modifiers indicating that the procedure/ infusion was not done. You may not bill Medicare for drugs not given to the patient. If this is not true, re-bill the claim or get corrected by phone. |
| 116 | The advanced indemnification notice signed by the patient did not comply with requirements. | Yes | The patient signed an ABN or other notice stating that they would be responsible (or someone would), if the claim is denied. However, the insurance company maybe audited that form and now is delegating the responsibility to you. You need to check the form and its compliance with requirements. If you are compliant, appeal with correct form or appeal the denial. |
| 117  | Transportation is only covered to the closest facility that can provide necessary care | No | Transportation is rarely covered at all, unless it is a lab test or an ambulance ride |
| 118 | ESRD Network Support Adjustment | No | This is a contractual adjustment for being part of an ESRD network. |
| 119 | Benefit maximum for this time period or occurrence has been reached. | Yes | This means the patient has hit a per claim or annual limit to their benefits. First, call the payer and ask them for an audit to justify this decision. Next, apply for patient assistance as the patient is rendered uninsured if this is an annual limit. |
| 121 | Indemnification adjustment—compensation for outstanding member responsibility | No | An adjustment has been made to the claim for patient responsibility due to the fact that they signed an indemnification agreement |
| 122 | Psychiatric reduction | No | Some payers, notably Medicare, reduce payments for a psychiatric diagnosis. That is why it is a good idea not to put depression, anxiety, and other similar diagnoses on the claim UNLESS you are evaluating or treating it. If you coded this on the claim in error, cancel claim and re-bill or ask for a telephonic correction. |
| 128 | Newborn’s services are covered in the mother’s Allowance | No | Nothing. This frequently happens with OB cases. But, if there’s a chance you could get some more coverage under the father’s coverage, bill to that payer. |
| 129 | Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reason Reject Code, or Remittance Advice Remark Code that is not an ALERT.) | Yes | Look at the Remark Code(s) and the claim submitted and try to figure out what happened to cause a retroactive rejection. Correct the claim and re-bill if you can or try a telephonic redetermination.  |
| 130 | Claim submission fee | No | Some crazy insurance company wants to charge a fee for submitting claims. They have a lot of nerve! Seriously, this can occur if you are still submitting paper claims. |
| 131 | Claim specific negotiated discount | No  | The provider granted a discount to the payer. Make sure this is true. |
| 132 | Pre-arranged Demo Project Adjustment | No | This is a fee adjustment for a demonstration project |
| 133 | The disposition of this service line is pending further review. (Use only with Group Code OA). Note: 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). This change effective September 1, 2017: The disposition of this service line is pending further review. (Use only with Group Code OA).  | No | The claim is being pended. Call the payer to see exactly what they need for adjudication. |
| 134 | Technical fees removed from payment | Yes | The payer is not paying you for the technical component of the service. This can happen for several reasons, but one of them is because you are not contracted with the payer as an imaging provider for the technical component. Check on this. If you have equipment and are contracted, appeal this. |
| 135 | Interim bills cannot be processed | No | The payer does not see this as the final bill for a particular date of service and is not paying you. Or, they see this as one of a series (a hospital outpatient type of billing). Check as to what the reason for this edit might be and try to take care of it by phone. |
| 136 | Failure to follow prior payer’s coverage rules (Use Group Code OA). | Yes | The secondary payer is not paying you because the primary payer’s rules were not followed. Check the primary payer EOB, plus their contract, and see whether the claim follows procedure. |
| 137 | Regulatory Surcharges, Assessments, Allowances of Health Related Taxes. | No | Taxes are being deducted from your payment. This may be due to fines levied by a city, county or public payer. |
| 138 | Appeal procedures not followed or time limits not met | Yes | This is serious because it can jeopardize your ability to get drug replacement from the manufacturer. If the time frame is the issue, there may be nothing you can do unless you can prove otherwise. Things like practice downtime, disasters, or outages can be a reason to re-open. If the appeal is turned down, call the plan and try to re-appeal. |
| 139 | Contracted funding agreement – Subscriber is employed by the provider of services. | No | This is a contractual adjustment for treating an employee of your practice. |
| 140 | Patient/Insured health identification number and name do not match. | Yes | Check the patient’s HIN as well as thoroughly checking the name on the insurance card. Cancel claim and re-bill with the right information or get corrected by telephone. |
| 142 | Monthly Medicaid liability amount | No | This patient has a Medicaid Share of Cost. Collect from the patient. |
| 143 | Portion of payment deferred | No | Part of the payment is being deferred into a risk pool or other arrangement. Make sure you are part of this arrangement. |
| 144 | Incentive adjustment | No | There is a claim adjustment based on an incentive in your contract. If this is a negative adjustment, check your contract. |
| 146 | Diagnosis was invalid for the reported date of service | Yes | The diagnosis is inconsistent with the date of service. Usually, this is due to using an outdated code. But, can be based on the individual patient. For example, the patient has a left breast cancer diagnosis code, but the patient had a left mastectomy years before. Look at the reasonableness of the ICD-10 code reported. Or, appeal the claim. |
| 147 | Provider contracted/ negotiated rate expired or not on file. | No | Check your contract, it may have expired and you no longer have a specific contract rate. Thus, the payer is taking an adjustment. Appeal if this is not the case. |
| 148 | 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 Remittance Advice Remark Code or NCPDP Reject Reason Code that is not an ALERT). | Yes | We have seen this denial code used when you do not have a referral from a PCP. Check the remark code to see if this is the case. Check with the appropriate provider. Submit documentation. If there is no documentation, apply for Patient Assistance if the patient’s care is denied. |
| 149 | Lifetime maximum has been reached for this service or benefit category | Yes | This is bad---request an immediate accounting from the plan or benefit manager of employer. The patient is uninsured for this benefit category, whatever you are billing. Apply for Patient Assistance ASAP, if this is a drug category. |
| 150 | Payer deems the information submitted does not support the level of service. | Yes | Either the claim or documentation does not meet the payer’s expectation. Call the payer or e-mail them and ascertain what they might need to pay the claim. If you have submitted documentation, send proof of what you have sent or re-send it. |
| 151 | Payment adjusted because the payer deems the information submitted does not support the many/frequency of services. | Yes | There is an edit on the quantity of drug or service reported on the claim. If this is not in agreement with the drug package insert or compendia research, appeal the claim with documentation from the ordering physician |
| 152 | Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Payer deems the information submitted does not support this length of service.  | Yes | There is an edit on duration of therapy or on the duration of drug administration. If this may not be in agreement with the drug package insert or compendia research, appeal the claim. Make sure there is appeal documentation from the ordering physician in terms of length of infusion or length of therapy. |
| 153 | Payer deems the information submitted does not support this dosage. | Yes | There is an edit on the quantity of drug or service reported on the claim. If this is not in agreement with the drug package insert or compendia research, appeal the claim with documentation from the ordering physician in terms of the dosage ordered and the quantity justification |
| 154 | Payer deems the information submitted does not support this day’s supply | Yes | There is an edit on the quantity of drug or service reported on the claim. If this is not in agreement with the drug package insert or compendia research, appeal the claim with documentation from the ordering physician |
| 155 | Patient refused the service/procedure. | Yes | The payer thinks that the patient refused the procedure. If drug was wasted and this is not Medicare, check your contract to see if this is a legitimate claim for that payer in terms of paying for the waste. Medicare does not pay for waste if the drug was never given to the patient. |
| 157 | Service/procedure was provided as a result of an act of war. | Yes | The payer is refusing the claim because they believe one of the Veterans’ organizations (CHAMPUS or VA) should pay the claim. Query that patient or caregiver to ascertain military coverage. |
| 158 | Service/procedure was provided outside the United States. | Yes | Did you provide drug for use outside the U.S.? The plan ill not pay so the patient should cover it. |
| 159 | Service/procedure was provided as a result of terrorism. | Yes | Really? Ascertain if the federal government or FEMA has set up funding for victims. Hope to never see this in reality. |
| 160 | Illness/injury was the result of an activity that is a benefit exclusion. | Yes | The payer believes that they have no liability for this claim, due to accident, injury, military exclusion, or work related issues. Query the patient or caregiver to verify and re-bill. Or, appeal if this is not true. |
| 161 | Provider performance bonus. | No | It is a bonus…enjoy! |
| 163 | Attachment or other documentation referenced on the claim was not received. | Yes | Attachment was not received. Put a tracer on it or re-send. |
| 164 | Attachment or other documentation referenced on the claim was not received in a timely fashion. | Yes | Attachment was not received and the time limit for that claim has expired. For Medicare, this is 45 days for an ADR or one year. Check with private payer contracts and state laws. This also can reference prior authorization documentation—trace sending of documentation and substantiate timeliness in compliance with contract or payer requirements. |
| 165 | Referral absent or exceeded. | Yes | This is a serious problem because the primary (or other) referral was not received or has expired. Verify that this is true and try for retroactive coverage by the referral source. Apply to patient assistance ASAP, if this is the only option. |
| 166 | These services were submitted after this payer’s responsibility for processing claims under this plan ended. | Yes | This has been billed to the wrong payer due to a shift in claims processing. Research and re-bill. |
| 167 | This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | Read the explanation---is this a coding problem or a coverage problem? If you believe the diagnosis is correct, have the claim reviewed by a Certified Coder and/or send literature supporting the diagnosis billed. |
| 168 | Service(s) have been considered under the patient’s medical plan. Benefits are not available under this dental plan. | Yes | For some reason, this may have been billed to the dental plan. It is now being reviewed by the medical portion of the plan. |
| 169 | Alternate benefit has been provided. | No | Patient has alternate coverage (outside the normal pharmacy or major medical benefit) for this drug or service. This can happen if a patient has a cancer policy or rider. Make sure that this explanation is correct. |
| 170 | Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | This most likely happens when an NPP is billing and they are not a provider with the payer. It can also happen with imaging. For NPPs, re-bill under the doctor’s number if appropriate and acceptable to the plan. If your practice is not an approved imaging provider, try to get on the panel retroactively. |
| 171 | Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | There is not coverage in this facility type for this type of provider. May happen when NPPs perform services in the hospital, home, SNF, or other facility. Check with the plan and see if they can bill incident to the provider. |
| 172 | Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | No | This usually typifies a reduction for NPPs. There is usually nothing much you can do about this, unless it is a violation of your contract… |
| 173 | Service or equipment was not prescribed by a physician. | Yes | State laws or contract parameters do not allow for products prescribed by someone other than a doctor. Verify that this is true before writing off. This edit can also be used retrospectively due to an audit here no order is found. Apply for drug replacement as appropriate. |
| 174 | Service was not prescribed prior to delivery. | Yes | DME or drug was not prescribed prior to delivery. This is usually discovered in an audit and is not generally appealable. |
| 175 | Prescription is incomplete. | Yes | Complete prescription and submit. Or, appeal if this is not the case. |
| 176 | Prescription is not current. | Yes | This edit may happen if a 30-dy supply is required and the prescription is older than that. Complete prescription and submit. Or, appeal if this is not the case |
| 177 | Patient has not met the required eligibility requirements. | Yes | The patient is not eligible for insurance or their coverage does not extend to the product or service offered. It may be that the patient had a ‘waiting period’ with a new employer. If this is true, have the patient apply for Patient Assistance as appropriate as they are uninsured for this drug (or service). |
| 178 | Patient has not met the required spend down requirements. | Yes | Most likely, the patient is Medicaid Share of Cost and needs to spend down to be insured. Collect from the patient. |
| 179 | Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | This patient is awaiting eligibility for insurance. They are currently in the waiting period and have no coverage. Apply for Patient assistance, until coverage is enacted. |
| 180 | Patient has not met the required residency requirements. | Yes | This is usually related to State or federal programs. Determine the waiting time and apply for Patient Assistance. |
| 181 | Procedure code was invalid on the date of service. | Yes | Update your code book and re-bill with the right code. This most often happens when a C-code or J-code is billed before the date of service for which it was approved. |
| 182 | Procedure modifier was invalid on the date of service. | Yes | Update your code book and re-bill with the right modifier. Remember that coding decisions are triggered by the patient’s date of service. |
| 183 | The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | Get the correct referral and referral number; then re-bill. |
| 184 | The prescribing/ ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | The prescribing or ordering physician or NPP was not eligible to prescribe these services and the payer rejected this. Re-do prescription with an eligible prescriber or see if there is an eligible Specialty Pharmacy. |
| 185 | The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: 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  | Yes | The rendering prescriber is not eligible to perform the billed service. Check to see if this is billed by an NPP or new physician that has not been approved by the plan. Re-bill as appropriate with a valid physician number. |
| 186 | Level of care change adjustment. | No | The payer is adjusting payment due to the level of care where the service was rendered. Can be an E/M edit. The service may have been approved prior to treatment at another level of care. Appeal, if this is not the case. |
| 187 | Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.) | No | The payment has been adjusted for coordination of benefits from other accounts, such as health spending, cafeteria, health savings, etc. |
| 188 | This product/procedure is only covered when used according to FDA recommendations. | Yes | This product has been used off-label or in violation of its package insert. If this is a cancer drug, it may be appealed with compendia or articles per both State and Federal laws. Make sure the appeal is signed by the prescribing physician. |
| 189 | “Not otherwise classified” or “unlisted” procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service. | Yes | Remember that coding decisions are triggered by the date of service. Cancel claim and re-bill with the existing code. |
| 190 | Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. | Yes | This payment has been bundled into SNF payments. We strongly suggest you bill the SNF if they knowingly sent the patient to you. Have contracts with all SNFs in your area to make sure you get paid. |
| 192 | Non-standard adjustment code from paper remittance. Note: 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. This change effective September 1, 2017: 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.  | No | This is a reconciliation between electronic and paper claims by 2 payers who are trying to coordinate benefits. If you do not bill on paper, should question this adjustment with the payer. |
| 193 | Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly | No | The original claim payment or rejection is being upheld. Appeal or rejoice as appropriate. |
| 194 | Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. | Yes | If you have approval for this patient or generally to do anesthesia, appeal the claim. If this is Medicare, review the recent moderate sedation rules as applicable. |
| 195 | Refund issued to an erroneous priority payer for this claim/service. | Yes | You assigned this claim to an erroneous payer who is getting a refund for this service. Re-bill to the right priority payer. |
| 197 | Precertification/ authorization absent. | Yes | The payer is unable to pay because the pre-auth or pre-cert is missing. Please re-submit or apply for Patient Assistance. |
| 198 | Precertification/ authorization exceeded. | Yes | The pre-auth has been granted for a period of time and that time has been exceeded. Please apply for a new prior auth ASAP. The patient now has no coverage for the service, unless this judgment is wrong. Apply for Patient Assistance, unless you can appeal or get retroactive approval.. |
| 199 | Revenue code and procedure code do not match. | Yes | This is normally a hospital outpatient denial. The revenue code for drugs is 0696 and for chemotherapy is 0335. Cancel claim and re-bill with right code. |
| 200 | Expenses incurred during lapse in coverage. | Yes | Unfortunately, this patient was not covered when the billing occurred. This is hard to appeal, but ask for proof. If this coverage gap is supposed to last, apply for Patient Assistance. |
| 201 | Workers’ Compensation case settled. Patient is responsible for amount of this claim/service through WC “Medicare set aside arrangement” or other agreement (Use group code PR). | Yes | Workers’ Comp is not paying, but you can go ahead and charge the patient. |
| 202 | Non-covered personal comfort or convenience services. | Yes | Patient convenience or comfort items are not covered, unless there are really extenuating circumstances (e.g. wigs for cancer in a few cases). Bill the patient, if they agree to it in writing. |
| 203 | Discontinued or reduced service. | No | Usually this code is generated because of modifiers that are used to portray reduced or discontinued services. If you did not generate these modifiers, appeal the reduction. |
| 204 | This service/equipment/ drug is not covered under the patient’s current benefit plan. | Yes | The patient does not have a benefit for the product or service billed. If this is a pharmacy benefit, check to see if the drug can be switched to a major medical benefit or to a specialty pharmacy benefit. The other reason you may see this code is WHITE BAGGNG. Plans substitute specialty pharmacy for coverage of “Buy and Bill”. |
| 205 | Pharmacy discount card processing fee. | No | Fee discounted for pharmacy discount card |
| 206 | National Provider Identifier – Missing. | Yes | Put in the NPI and re-bill or resolve in telephonic appeal |
| 207 | National Provider Identifier – Invalid format. | Yes | Put in the corrected NPI and re-bill or resolve in telephonic appeal |
| 208 | National Provider Identifier – Not matched | Yes | Put in the corrected NPI and re-bill or resolve in telephonic appeal |
| 209 | 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 Group code OA) | Yes | Do not bill this to a patient, but you may bill to a secondary or tertiary payer. |
| 210 | Payment adjusted because pre-certification/authorization not received in a timely fashion. | Yes | Your prior auth was not received in the required time. Appeal this if it is not per your contract or stipulated parameters. Otherwise, apply for Patient Assistance. |
| 211 | National Drug Codes (NDC) not eligible for rebate, are not covered. | Yes | This is not your fault. The manufacturer has not paid Medicaid rebates and the drug is not covered. Apply for Patient Assistance. |
| 212 | Administrative surcharges are not covered. | Yes | Administrative surcharges (or facility fees) were charged and these are not paid. |
| 213 | Non-compliance with the physician self-referral prohibition legislation or payer policy. | No | This is a big problem. Your practice has violated the physician self-referral law or policy in some way. This take-back is probably the result of an audit or whistleblower. Contact a lawyer ASAP. |
| 215 | Based on subrogation of a third party settlement. | Yes | The claim has been subrogated to another party based on a settlement---usually another form of insurance is now responsible for the claims, e.g. auto, professional liability, legal counsel, abrbitrator etc |
| 216 | Based on the findings of a review organization. | Yes | This is a take-back based on the findings of a review organization. It can also be favorable, but usually not. File an appeal as necessary to the next level of review. |
| 219 | Based on extent of injury. Note: 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 region. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy200 | No | Payment has been adjusted by Workers’ Comp based on the extent of the patient’s injury. Read the messaging and see if clinically this payment can be appealed. |
| 222 | Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present. | Yes | This can mean that the number of units of E/M, anesthesia, etc are impossible for *this provider* within a certain timeframe—which should be the subject of a contract. Read the message and see if this is actually true. Appeal as necessary. NOTE: This is for all patients not anyone in particular. |
| 223 | Adjustment code for a 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. | Yes | There is no existing adjustment code for this adjustment; but, it is probably unavoidable as it is mandated by law. Look for this with government hold-backs such as sequestration or mandatory reductions. |
| 224 | Patient identification compromised by identity theft. Identity verification required for processing this and future claims. | Yes | Heads up…this is a problem. The insurance company has seen identity theft in your patients or in your area. Verify if this is true and provide positive identification. Then, check all your EOBs to ensure that your patients’ identities are not being used to generate false claims from a false billing address. Also, you need to make sure there has not been a HIPAA leak in your practice from the staff or lost computer. |
| 225 | The payment is being adjusted to include a late penalty or interest payment to the practice from the payer. | No | Payer is paying you interest or a penalty because their payment processes exceed the contracted time frame…good news! |
| 226 | Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code that is not an ALERT). | Yes | The payer has requested information from the provider; the provider’s response was insufficient. This most often happens with new drugs. Make sure you have sent an H&P or the whole record, the package insert from the drug, NDC number, vial size, the latest pricing, and the dose given to this patient.  |
| 227 | 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 Remittance Advice Remark Code or NCPDP Reject Reason Code that is not an ALERT). | Yes | The payer requested specific information from the PATIENT that was not provided. See what it is and ensure that treatment or billing cease until the patient or caregiver provides the requested information. |
| 228 | Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication | Yes | Somebody needs to supply information for the claim to get paid. Most often, this is another provider. Read the remarks carefully and get the appropriate information so you can bill. |
| 229 | Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: 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 Group Code PR | Yes | The claim is not being considered for partial payment because of the type of claim submitted (12X). This is a coordination of benefits bill type. Thus, the secondary payment should be paid by the patient, not by the secondary. Check all intake information for this patient and make sure they are not Medicaid secondary before charging them. |
| 231 | Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | The payer states that two procedures have been billed on the same day that cannot be billed together. If you disagree with that assessment, appeal the claim and request that it is reviewed by a Certified Coder. |
| 232 | Institutional Transfer Amount. Note – Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions. | No | This is a DRG adjustment when a patient transfers allowing for proportional payment to receiving institutions. |
| 233 | Services/charges related to the treatment of a hospital-acquired condition or preventable medical error. | No | This is hospital adjustment when the discharge evidences an error or iatrogenic condition related to the hospitalization. |
| 234 | 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). | Yes | The payer is not paying the code separately either due to a bundling edit on the code or due to a contracted bundled payment. If this is not true in this case, appeal the claim and request a review by a Certified Coder. |
| 235 | Sales Tax | No | Sales tax has been adjusted from the payment for this claim. It may be billed to the patient, as appropriate. |
| 236 | 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’ Comp fee schedule. | Yes | The procedure and/or the procedure/modifier combination is not in accordance with the Correct Coding Initiative or Workers’ Comp edits. Unless this is a highly unusual case, do not appeal. Check the edit at the CCI web site at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/  |
| 237 | 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.) | No | This claim is being denied or reduced for regulatory reasons. This may happen due to a quality penalty or regulatory penalty for a specific reason. This code is used for the adjustment due to the e-prescribing penalty in 2012. This is not appealable. |
| 238 | Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). | Yes | The claim is being reduced because the claim is outside the patient’s eligibility period from their employer or through an exchange. Check with the patient’s policy or employer to verify that this is true.  |
| 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA). | Yes | Re-bill with eligible and ineligible periods if applicable. The claim is being reduced because the claim is outside the patient’s eligibility period. Check with the patient’s policy or employer to verify that this is true. |
| 240 | The diagnosis is inconsistent with the patient’s birth weight | Yes | There probably should be a diagnosis code indicated the patient’s low birth weight or failure to thrive |
| 241 | Low Income Subsidy (LIS) Co-payment Amount | No | This is usually part of a pharmacy claim for Part D. |
| 242 | Services not provided by network/primary care providers. | Yes | This is an out of network claim. If you can, you must bill the patient or apply to be in-network |
| 243 | Services not authorized by network/primary care providers. | Yes | There should have been a referral or authorization from the Primary Care Physician or the IPA. See if you can get one or apply for Patient Assistance |
| 245 | Provider performance program withhold | No | Payment has been reduced because the provider is being penalized for not participating in pay-for-performance (PQRS, EMR, VM, etc) |
| 246 | This non-payable code is for reporting only | No | This is a code that is submitted to satisfy reporting requirements but it does not pay anything |
| 247 | Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. | No | This is a withhold for a deductible on a professional service billed by a hospital or other institution |
| 248 | Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. | No | his is a withhold for coinsurance on a professional service billed by a hospital or other institution |
| 249 | This claim has been identified as a readmission. (Use only with Group Code CO) | No  | This is a quality indicator for hospitals, but may have implications for Medical Home or other program practices |
| 250 | The attachment/other documentation content received is inconsistent with the expected content. | Yes | What the payer asked for in terms of documentation has not been satisfied by what has been sent. This code is on the increase. |
| 251 | 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).  | Yes | Documentation sent on this claim was not enough to get the claim processed and the payer requested further documentation…ascertain what they need and re-submit the documentation. We have seen this be pricing information. |
| 252 | 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). | Yes | The payer is asking for more documentation to pay the claim. Check the remark code and send what they need. |
| 253 | Sequestration - reduction in federal spending | No | This is the 2% sequestration hold back on your money. Call congress and get rid of it—just kidding. |
| 254 | 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. | Yes | The claim was sent to the dental rather than the medical benefit. Re-submit to the right plan. |
| 256 | Service not payable per managed care contract. | Yes | This is usually due to capitation or other bundled contracts. Check your contract with this payer. If this denial was in error, appeal the claim |
| 257 | 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) | No | The patient has an ACA Exchange insurance. It is unknown whether the patient will pay their bill and whether the insurance will be cancelled. Verify with the patient that they have paid their premium; when it was paid; and what the proof of payment is. Then, verify with the payer that they have received it. |
| 258 | Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service. | Yes | Your patient is a prisoner. Did you not notice the handcuffs and leg irons? They may qualify for Medicaid our County Assistance in some states or they might qualify for PAP. |
| 259 | Additional payment for Dental/Vision service utilization | No | Patient had dental or vision services which are other benefits—service must be billed to the specific dental or vision intermediary. |
| 260 | Processed under Medicaid ACA Enhanced Fee Schedule | No | An Enhanced Medicaid Fee Schedule is an oxymoron---nothing you can do |
| 261 | The procedure or service is inconsistent with the patient's history. | Yes | This may mean you are giving the wrong line of therapy for the patient. Check and see what the label says and determine if you can appeal. |
| 262-266 | Adjustments for delivery, postage, shipping, administrative, and preparation costs | No | These are contracted adjustments for specialty pharmaceuticals or labs |
| 267 | Claim spans multiple months. Rebill as a separate claim or service. | Yes | Even in hospitals, all claims must be within one month if billed together |
| 268 | Claim spans 2 calendar years—must be billed as one claim per year | Yes | This is an edit for series billing over 2 separate calendar years and probably separate months. Bill each month separately. |
| 269 | Anesthesia not covered for this service or procedure. | Yes | If you gave anesthesia, please appeal supporting the reason why you used it. This appeal should be signed by the treating physician. |
| 270 | Claim submitted through major medical, but no benefits under medical. Might be dental | Yes | This does not appear to be a medical procedure or the patient does not have a major medical and gave you a dental card. Check the patient’s card and claim and make sure it was portrayed correctly. Appeal as necessary |
| 271 | Prior contractual adjustments related to current periodic payment as part of a contractual schedule | No | Hospitals sometimes get Periodic Payments as do some capitated providers, meaning that detailed claims can only be paid, if they are ‘carve outs’ |
| 272 | Coverage/program guidelines were not met | Yes | Appeal if you think the facility, provider, service and patient should be covered under this payer and/or program |
| 273 | Coverage/program guidelines were exceeded | Yes | Appeal if you do not believe you exceeded nothing for the program or the coverage of the patient---this can be used for visits, SNF days, or hospital days. |
| 274 | Fee/service not payable per Patient Care Coordination arrangement | Yes | This may be due to the fact that certain services may only be treated in the Patient-Centered Medical Home or by a Primary Care. Appeal if you do not believe this to be the case. |
| 275 | Prior payers’ patient responsibility not covered | Yes | A secondary insurance will not pick up the patient responsibility. Apply for Foundation or co-pay card |
| 276 | Services denied by a prior payer were not covered by this payer | Yes | A secondary payer will not pay for a denied service from the primary payer, so it is important to get the primary payer to pay for it or apply for Patient Assistance |
| 277 | The disposition on this service is undetermined because it is the premium grace period per a Health Insurance SHOP exchange. The claim will be reversed or corrected once the grace period ends | Yes | Make sure your patient is paying their ACA premiums during the grace period |
| 278 | Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment  | Yes | Your practice or provider(s) are not meeting program proficiency requirements. This is required either to get a bonus or payment for specific procedures. |
| 279 | Services not provided by Preferred network providers.  | Yes | Practitioner providing item or service is not in-network. Offer out-of-network fees. |
| 280 | 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.  | Yes | The medical portion of the plan is not paying, but there is hope. Submit the claim to the pharmacy benefit for the patient. |
| A0 | Patient refund amount. | No | Patient refund due |
| A1 | Claim/service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code that is not an ALERT). | Yes | This is not a helpful code. Please read remarks carefully and appeal as necessary. |
| A5 | Medicare Claim PPS Capital Cost Outlier Amount. | No | This payment is for an inpatient cost outlier as reported by the hospital. |
| A6 | Prior hospitalization or 30 day transfer requirement not met. | No | This is for a patient in a Skilled Nursing Facility who did not meet a qualifying stay. |
| A8 | Ungroupable DRG | No | Record’s principal diagnosis or procedure does not group to a DRG |
| B1 | Non-covered visits. | Yes | This is usually used for visits in the Global Surgical Period, but can be used any time a visit is denied. Appeal if this is not a global period violation and have Certified Coder review. |
| B4 | Late filing penalty | No | Penalty is levied for late filing. Check your contract and make sure that this penalty is part of your contract. |
| B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective September 1, 2017: 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.  | Yes | The provider was not eligible to be paid for the service based on not being on the panel or not being certified for the service. See if this can be billed under another provider’s supervision. |
| B8 | Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Yes | For drugs, this is most often used when there is generic substitution or the payer wants you to use Specialty Pharmacy. Check to make sure these are spelled out in your contract or in the patient’s policy. If true or not, appeal based on medical necessity. |
| B9 | Patient is enrolled in a Hospice. | Yes | Patient is enrolled in a hospice and should not be receiving care that is for non-palliative care. Make sure that this is the case or appeal as palliative care. |
| 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. | Yes | Appeal if you do not believe that the basic procedure has been paid. This may be used for additional hours of drug administration or sequential infusions, which are billable and allowable. |
| B11 | The claim/service has been transferred to the proper payer/processor for processing. Claim/ service not covered by this payer/processor. | Yes | The insurer does not believe that they are the proper payer. They have forwarded it to the proper payer. Do nothing. |
| B12 | Services not documented in patients’ medical records. | Yes | The payer has reviewed documentation and does not believe they have to cover services. This is generally a result of an audit. Ensure that the responsible provider appeals this case with proper documentation. |
| B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment. | Yes | The payer believes that they have previously paid for this service or that it is a duplicate claim. Appeal if this is not true, if you verify no claim for this date of service. |
| B14 | Only one visit or consultation per physician per day is covered. | Yes | This means that more than one E/M service was billed for this physician or someone of their specialty or practice on the same day. Appeal if this is not true and you verify no claim for this date of service. |
| B15 | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present | Yes | This usually occurs when a sequential drug administration service is not billed on the same date or same claim as the initial drug administration service. It can also be used when an advanced line drug is billed as first line. therapy is not being followed per the labeled indication for a drug. Appeal as appropriate. |
| B16 | “New Patient” qualifications were not met. | Yes | A new patient is one who has not been seen in any setting by someone of your SPECIALTY (Medicare) or subspecialty (Others) in 36 months. This is a violation of this policy. Appeal if you disagree. |
| B20 | Procedure/service was partially or fully furnished by another provider. | Yes | Claims data shows duplicative services by another provider. Ascertain from the payer WHO provided them and verify this is true. If not, appeal or re-bill with a modifier. |
| B22 | This payment is adjusted based on the diagnosis. | Yes | Usually this adjustment occurs because a mental health diagnosis is on the claim. Check this out and make sure that is what is being treated; otherwise, re-bill with a medical diagnosis. |
| B23 | Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. | Yes | Our practice or another lab does not have the CLIA designation to bill this test. |
| P1-P23 | Auto & Casualty, Workers’ Comp Contractual Codes | Yes | Not likely used in Oncology |