Status	MHC Adjustment Code (HC412.11)		HIPAA Adjustment Translation (ADJCODES.XLATE)	
	CODE	Description	CODE	Description
Reversal	A1	ADJUSTMENT TO RECOVER PREVIOUS PAYMENT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
Reversal	A10	AUTHORIZED LIABILITY	169	Alternate benefit has been provided.
Reversal	A11	ADDITIONAL FORMS RECEIVED: CLAIM REPROCESSED	169	Alternate benefit has been provided.
Reversal	A14	CHECK RETURNED/REFUND;CLAIM REPROCESSED	169	Alternate benefit has been provided.
Reversal	A15	REFERRAL FOUND AFTER ADDITIONAL REVIEW	169	Alternate benefit has been provided.
Reversal	A16	CLAIM REVERSED FOR EDITING	169	Alternate benefit has been provided.
Reversal	A17	SEE MEMBER ID#-PLEASE UPDATE RECORD	169	Alternate benefit has been provided.
Reversal	A18	ADJUSTMENT-REFLECTS COST OUTLIER	70	Cost outlier - Adjustment to compensate for additional costs.
Reversal	A19	ADJUSTMENT-HOSPITAL RE-ADMISSION	A6	Prior hospitalization or 30 day transfer requirement not met.
Reversal	A2	ADMINISTRATIVE/MEDICAL ADJUSTMENT	169	Alternate benefit has been provided.
Reversal	A20	ADJUSTMENT-REFLECTS DAY OUTLIER	69	Day outlier amount.
Reversal	A21	ADJUSTMENT-DRG PAYMENT DUE TO HOSPITAL TRANSFER	87	Transfer amount.
Reversal	A22	ADJUSTMENT-SEE CORRECTED MEMBER ID# ON EOB. PLEASE UPDATE YOUR RECORDS.	140	Patient/Insured health identification number and name do not match.
Reversal	A23	PAYMENT ADJUSTED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYOR	169	Alternate benefit has been provided.
Reversal	A24	ADJUSTMENT TO MEMBER ACCUMULATOR	169	Alternate benefit has been provided.
Reversal	A25	SYSTEM EDIT INDICATED POTENTIAL DUPLICATE; HOWEVER, AFTER REVIEW DUPLICATE NOT FOUND	169	Alternate benefit has been provided.
Reversal	A26	ALLOWED ITEM	169	Alternate benefit has been provided.
Reversal	A27	ALLOWED ITEM	169	Alternate benefit has been provided.
Reversal	A28	HOSPITAL IDENTIFIED READMISSION	A6	Prior hospitalization or 30 day transfer requirement not met.
Reversal	A3	APPEAL/GRIEVANCE - DENIAL OVERTURNED	169	Alternate benefit has been provided.
Reversal	A30	DRG CODE SUBMITTED ON CLAIM IS NOT THE SAME DRG CODE AS DETERMINED BY GROUPER 23. PAYMENT IS BASED ON THE DRG CODE IS DETERMINED BY GROUPER 23.	169	Alternate benefit has been provided.
Reversal	A31	CLAIM ADJUSTED BASED ON CONTRACTED STOP LOSS AMOUNT	169	Alternate benefit has been provided.
Reversal	A32	CLAIM ADJUSTED BASED ON IMPLANTABLE ITEM	169	Alternate benefit has been provided.
Reversal	A4	APPEAL/GRIEVANCE - DENIAL UPHELD	138	Appeal procedures not followed or time limits not met.
Reversal	A5	APPEAL/GRIEVANCE - PAYMENT UPHELD	169	Alternate benefit has been provided.
Reversal	A6	CLAIM PROCESSING ERROR - CORRECTED	169	Alternate benefit has been provided.
Reversal	A7	INCORRECT QUANTITY-CLAIM CORRECTED	169	Alternate benefit has been provided.
Reversal	A8	EMERGENT DIAGNOSIS	169	Alternate benefit has been provided.
Reversal	A9	AUTHORIZED EMERGENCY ROOM VISIT	169	Alternate benefit has been provided.
Claim Check	C10	ALL LINES DENIED - DIFFERENT ADJUSTMENT CODES	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.
Claim Check	C11	REPLACED FOR INTENSITY OF SERVICE VS DIAGNOSIS	B22	This payment is adjusted based on the diagnosis.

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	CODE	Description	CODE	Description
Claim Check	C12	MULTIPLE PROCEDURE PLAN LIMIT	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Claim Check	C13	MEDICAL VISIT NO PAYMENT	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.
Claim Check	C14	INCIDENTAL PROCEDURE NO PAYMENT	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.
Claim Check	C15	MUTUALLY EXCLUSIVE PROCEDURES	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.
Claim Check	C16	REBUNDLING OF CODES	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.
Claim Check	C17	PROCEDURE CODE REPLACED OR REBUNDLED	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
Claim Check	C18	DEFAULT CLAIM LINE DENIAL	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.
Claim Check	CC	CODE ADDED PER CLAIM CHECK EDITING	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.
Claim Check	CC1	ASSISTANT SURGEON OR PHYSICIAN ASSISTANT AT SURGERY NOT REQUIRED	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.
Claim Check	CC2	REPLACED NEW VISIT CODE WITH ESTABLISHED VISIT CODE	B16	New Patient' qualifications were not met.
Claim Check	CC4	DENIED-SERVICES WITHIN SURGERY POST OP DATE RANGE	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.
Claim Check	CC5	DENIED-SERVICES WITHIN SURGERY PRE OP DATE RANGE	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.
Claim Check	CC6	DUPLICATE PROCEDURE PERFORMED	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.

Status	MHC Adjustment Code (HC412.11) CODE	MHC Adjustment Code (HC412.11) Description	HIPAA Adjustment Translation (ADJCODES.XLATE) CODE	HIPAA Adjustment Translation (ADJCODES.XLATE) Description
Claim Check	CC7	REQUESTED AMOUNT MODIFIED	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.
Claim Check	CC8	SERVICES ITEMIZED FOR CLAIM EDITING	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.
Claim Check	CC9	AUTO-ADJUST	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.
Denial	D1	REJECTED-MEDICAL RECORDS REQUIRED	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D10	REJECTED-EXCEEDS MAXIMUM FILING TIME LIMIT	29	The time limit for filing has expired.
Denial	D100	DENIED-SYSTEM GENERATED DUPLICATE CLAIM/SERVICE PREVIOUSLY PAID	18	Duplicate claim/service.
Denial	D104	PAYMENT FOR THIS LINE ITEM IS INCLUDED IN CAPITATION	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.
Denial	D106	PAYMENT FOR THESE SERVICES IS INCLUDED IN THE PAYMENT OF THE VISIT	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.
Denial	D107	EPSDT SCREENING SERVICES/COMPONENTS NOT COMPLETED	169	Alternate benefit has been provided.
Denial	D108	THIS PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON	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.
Denial	D11	REJECTED - RESUBMIT WITH EOB FROM PRIMARY CARRIER TO INCLUDE REASON FOR DENIAL.	22	This care may be covered by another payer per coordination of benefits.
Denial	D12	DENIED-MOTOR VEHICLE ACCIDENT-AUTO INSURER IS PRIMARY/EOB	21	This injury/illness is the liability of the no-fault carrier.
Denial	D13	DENIED-WORKER'S COMPENSATION IS PRIMARY/EOB	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
Denial	D14	REJECTED-CLAIM & EOB MUST MATCH	16	Claim/service lacks information which is needed for adjudication. 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.)

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	CODE	Description	CODE	Description
Denial	D15	KEYSTONE HEALTH PLAN WEST IS CARRIER FOR THIS SERVICE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D16	REJECTED - DAVIS VISION IS CARRIER FOR THIS SERVICE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D17	REJECTED-ARGUS HEALTHCARE IS THE PHARMACY CARRIER RESPONSIBLE FOR THIS SERVICE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D18	DENIED-OTHER SERVICES INCLUDED WITH PAYMENT OF PRIMARY SERVICES	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.
Denial	D19	DENIED - THIS PROCEDURE CODE IS NOT COMPENSABLE UNDER MEDICAID/MEDICAL ASSISTANCE/MEDICARE OR GATEWAY	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.
Denial	D2	DENIED - NOT THE MEMBER'S CAPITATED PROVIDER	38	Services not provided or authorized by designated (network/primary care) providers.
Denial	D20	DENIED - OVER MAX PROCEDURE/LIMIT	119	Benefit maximum for this time period or occurrence has been reached.
Denial	D21	REJECTED-NO REFERRAL/INVALID/EXPIRED	165	Referral absent or exceeded.
Denial	D22	REJECTED-NO VALID PRECERT ON FILE	165	Referral absent or exceeded.
Denial	D23	DENIED-SAME SERVICE PAID TO A DIFFERENT PROVIDER OR BILLING PROVIDER INELIGIBLE TO SUBMIT CHARGES	B20	Procedure/service was partially or fully furnished by another provider.
Denial	D24	REJECTED-RELATED MATERNITY CLAIM NOT RECEIVED	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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Denial	D25	DENIED-DUPLICATE CLAIM PAID/DENIED PREVIOUSLY	18	Duplicate claim/service.
Denial	D26	DUPLICATE CLAIM-ORIGINAL CLAIM UNDER REVIEW	18	Duplicate claim/service.
Denial	D27	SUBMIT BILL TO MEDICAL ASSISTANCE FEE-FOR-SERVICE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D28	DENIED-EPSDT FORM INCOMPLETE	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D29	EMERGENCY ROOM VISIT NOT APPROVED	40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Denial	D3	REJECTED-AGE DISCREPANCY WITH PROCEDURE CODE BILLED; REFILE	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.

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	CODE	Description	CODE	Description
Denial	D30	DENIED-ADDITIONAL INFORMATION NEEDED TO SUPPORT PAYMENT	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D31	REJECTED-EPSDT FORM NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D32	DENIED-PRIOR PAYMENTS EQUAL DME PURCHASE AMOUNT	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Denial	D33	CHARGES OR UNITS NOT SUBMITTED ON BILL	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D34	ITEMIZE PAYMENTS BY CODE ON THE EOB	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D35	REJECTED-SUBMITTED BILL DOES NOT MATCH AUTHORIZATION	165	Referral absent or exceeded.
Denial	D36	REJECTED-DISCREPANCY IN LEVEL OF CARE WITH AUTHORIZATION	150	Payer deems the information submitted does not support this level of service.
Denial	D37	REJECTED-MUST USE CONTRACTED AND/OR AUTHORIZED PROCEDURE CODE(S)FOR AMBULANCE/TRANSPORT SERVICES	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.
Denial	D38	BABY NOT ENROLLED IN PLAN;REFILE WITH BABY'S GATEWAY ID NUMBER	32	Our records indicate that this dependent is not an eligible dependent as defined.
Denial	D39	REJECTED - REFILE WITH GATEWAY MEMBER ID NUMBER	31	Patient cannot be identified as our insured.
Denial	D4	REJECTED - INVALID MODIFIER, $0 PAYMENT MODIFIER OR INVALID MODIFIER/PROCEDURE CODE COMBINATION; REFILE.	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.
Denial	D40	DENIED-ANESTHESIA MINUTES REPORTED INCORRECTLY; RESUBMIT IN QUANTITY FIELD	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D43	RESUBMIT CLAIM TO DENTAL CARRIER	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D44	SUBMIT CLAIM TO BEHAVIORAL HEALTH PROVIDER	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Denial	D45	MEDICAL SERVICE NOT APPROVED PER CLAIMS ADMINISTRATION OR MEDICAL REVIEW.	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.

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	CODE	Description	CODE	Description
Denial	D46	MEDICAL RECORDS ARE INSUFFICIENT	B12	Services not documented in patients' medical records.
Denial	D47	REJECTED : PROVIDER ID OR NPI NUMBER AND TAX ID DO NOT MATCH.	125	Submission/billing error(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.)
Denial	D48	DENIED-DIAGNOSIS NOT CONSISTENT WITH MEDICAL REVIEW	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.
Denial	D5	REJECTED-INVALID PROCEDURE CODE;REFILE WITHIN THE FOLLOW UP TIME PERIOD	181	Procedure code was invalid on the date of service.
Denial	D50	DENIED FOR MULTIPLE REASONS	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Denial	D51	DENIED-SERVICES BILLED UNDER NEWBORN NUMBER	140	Patient/Insured health identification number and name do not match.
Denial	D52	DENIED-SERVICES NOT PAID UNTIL CONFINEMENT ENDS	135	Interim bills cannot be processed.
Denial	D53	LAB NOT AUTHORIZED OR PERFORMED BY NON-CAPITATED PROVIDER	38	Services not provided or authorized by designated (network/primary care) providers.
Denial	D54	DENY-NO REFERRAL AFTER 1ST/2ND REV	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
Denial	D55	CLAIMS COMBINED FOR EDITING	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.
Denial	D56	PROFESSIONAL FEES MUST BE BILLED WITH A MODIFIER	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.
Denial	D57	REJECTED-DRG CODE REQUIRED	A8	Ungroupable DRG.
Denial	D58	DENY-ADMINISTRATIVE	165	Referral absent or exceeded.
Denial	D59	RETRO-DISENROLLMENT;SUBMIT TO MEDICAL ASSISTANCE	141	Claim spans eligible and ineligible periods of coverage.
Denial	D6	REJECTED-ITEMIZED BILL WITH DATE OF SERVICE REQUIRED	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
Denial	D60	REJECTED-SUBMIT NDC CODE, NAME, DOSAGE, QUANTITY OR VERIFY QUANTITY OF BILLED CODE	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D61	PROCEDURES FOR BILLING W/GROUP,REFERRING,PERFORMING PROVIDER WERE NOT ALLOWED	B5	Coverage/program guidelines were not met or were exceeded.
Denial	D62	REJECTED-SEX DISCREPANCY WITH PROCEDURE CODE BILLED; REFI	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.
Denial	D63	REJECTED-EXPENSES INCURRED PRIOR TO COVERAGE	26	Expenses incurred prior to coverage.

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	CODE	Description	CODE	Description
Denial	D64	REJECTED - SERVICES MUST BE BILLED ON A HCFA OR UB FORM	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D65	DENIED-UB04 FORMS CANNOT BE PROCESSED UNLESS A VALID TYPE BILL IS SUBMITTED IN FIELD 4;RESUBMIT	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D66	DENIED - CLAIM DOES NOT HAVE ANY DIAGNOSIS CODE(S) ON THE BILL ONE OR MORE VALID DIAGNOSIS CODE(S) REQUIRED;RESUBMIT	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D67	DENIED-INFERTILITY SERVICES NOT COVERED BY MEDICAL ASSISTANCE OR GATEWAY	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.
Denial	D68	DENIED - RENAL DIALYSIS SERVICES ARE NOT A PART OF YOUR BENEFIT PACKAGE UNDER MA OR GATEWAY	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.
Denial	D69	DENIED - NOT MEDICALLY 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.
Denial	D7	REJECTED - DIAGNOSIS INVALID, INVALID FOR DATE OF SERVICE NOT CONSISTENT WITH PROCEDURES BILLED.	146	Diagnosis was invalid for the date(s) of service reported.
Denial	D74	X-RAY'S PERFORMED BY A CHIROPRACTOR ARE NOT REIMBURSABLE	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.
Denial	D76	DENIED - AUTOPSY RELATED SERVICES ARE NOT COVERED	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.
Denial	D8	REJECTED-EXPENSES INCURRED AFTER COVERAGE TERMINATED	27	Expenses incurred after coverage terminated.
Denial	D80	OUR RECORDS SHOW THE DATE OF SERVICE WAS AFTER THE DATE OF DEATH	13	The date of death precedes the date of service.

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Denial	D81	DENIED-PROVIDER OPTED OUT OF MEDICARE & PATIENT IS RESPONSIBLE FOR PAYMENT UP TO LIMITING CHARGE AMOUNT	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.
Denial	D86	DENIED - SERVICES NOT COVERED BECAUSE THE PATIENT IS ENROLLED IN A HOSPICE	B9	Patient is enrolled in a Hospice.
Denial	D87	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS A ROUTINE EXAM OR SCREENING PROCEDURE IN CONJUNCTION WITH A ROUTINE EXAM	49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Denial	D88	DENIED - RENAL FACILITIES NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE	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.
Denial	D9	DENIED - BENEFITS TERMINATED FOR DATE OF SERVICE	39	Services denied at the time authorization/pre-certification was requested.
Denial	D90	MISSING/INCOMPLETE/INVALID CLAIM INFORMATION. RESUBMIT CLAIM AFTER CORRECTIONS.	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Denial	D91	PROCEDURE CODE/BILL TYPE NOT CONSISTENT WITH THE PLACE OF SERVICE CODE	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.
Denial	D92	DENIED - NOT COVERED BY NATIONAL OR LOCAL COVERAGE DETERMINATION	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.
Denial	D93	DENIED - EXPERIMENTAL OR INVESTIGATIONAL PROCEDURE OR SERVICE	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.
Denial	D97	MISSING OR INVALID PRESENT ON ADMIT INDICATOR. RESUBMIT WITH A VALID PRESENT ON ADMIT INDICATOR ON ALL PRINCIPAL AND SECONDARY DIAGNOSIS CODES.	16	Claim/service lacks information which is needed for adjudication. 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.)
Denial	D98	REJECTED-DEPENDING ON SERVICES RENDERED, AUTHORIZATION FROM NIA OR FAMILY HEALTH COUNCIL IS MISSING,INVALID OR EXPIRED	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
Denial	D99	REJECTED-RESUBMIT WITH INDIVIDUAL RENDERING PROVIDER INFORMATION	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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Status	MHC Adjustment Code (HC412.11)		HIPAA Adjustment Translation (ADJCODES.XLATE)	
	CODE	Description	CODE	Description
Informational	R1	CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan.
Informational	R10	NONCLEAN EDI-PROVIDER/OR MEMBER # NOT SUBMITTED	95	Plan procedures not followed.
Informational	R11	FEE/CODE UPDATE COMPLETED	147	Provider contracted/negotiated rate expired or not on file.
Informational	R12	PAYMENT REPRESENTS INTEREST AMOUNT	85	Patient Interest Adjustment (Use Only Group code PR)
Informational	R13	PAYMENT REFLECTS MEDICARE COB	20	This injury/illness is covered by the liability carrier.
Informational	R14	EPSDT PROCESSED AFTER MAID RESEARCH	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.
Informational	R15	AMOUNT PAID REPRESENTS EPSDT REIMBURSEMENT RATE	131	Claim specific negotiated discount.
Informational	R16	ADJUSTMENT TO PREVIOUSLY PROCESSED CLAIM DUE TO SPECIAL CLAIMS PROJECT.	63	Correction to a prior claim.
Informational	R2	PAYMENT REFLECTS NON-MEDICARE COB	23	The impact of prior payer(s) adjudication including payments and/or adjustments.
Informational	R20	INVALID PLACE OF SERVICE-CODE MAY HAVE BEEN CORRECTED TO ALLOW PAYMENT	125	Submission/billing error(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.)
Informational	R3	COMBINED MOTHER & BABY PAYMENT	128	Newborn's services are covered in the mother's Allowance.
Informational	R4	INTERIM BILL PAYMENT	143	Portion of payment deferred.
Informational	R5	CONTRACTED/NEGOTIATED RATE	131	Claim specific negotiated discount.
Informational	R6	REPROCESSED TO ALLOW CORRECTED PAYMENT AMOUNT	125	Submission/billing error(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.)
Informational	R7	PAID AT QUANTITY ALLOWED IN AUTHORIZATION	198	Precertification/authorization exceeded.
Informational	R8	CLAIM RESOLUTION FINALIZED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
Informational	R9	THIRD PARTY LIABILITY REFUND TO DPW	B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
	Additional System Generated Adjustments Codes			
			1	Deductible amount
			2	Coinsurance amount
			3	Co-payment amount
			23	Payment adjusted because charges have been paid by another payer.
			24	Payment for charges adjusted. Chargfes are covered under a capitation agreement/managed care plan.
			35	Lifetime benefit maximum has been reached
			42	Charges exceed out fee schedule or maximum allowable amount.
			45	Charges exceed your contracted/legislated fee arrangement.
			94	Processed in excess of charges
			97	Payment included in the allowance for another service/procedure
			104	Managed care withholding
			131	Claim specific negotiated discount