Reason Code	Remark Code	Reason for Denial
Reason Code 01		Deductible amount.
Reason Code 02		Coinsurance amount.
Reason Code 03		Co-payment amount.
Reason Code 04		The procedure code is inconsistent with the modifier used, or a required modifier is missing.
Reason Code 04	**M114 N565**	HCPCS code is inconsistent with modifier used or a required modifier is missing Item billed was processed under DMEPOS Competitive Bidding Program and requires an appropriate competitive bid modifier
Reason Code 04	**N519**	HCPCS code is inconsistent with modifier used or required modifier is missing
Reason Code 05		The procedure code/bill type is inconsistent with the place of service.
Reason Code 06		The procedure/revenue code is inconsistent with the patient's age.
Reason Code 07		The procedure/revenue code is inconsistent with the patient's gender.
Reason Code 08		The procedure code is inconsistent with the provider type/specialty (taxonomy).
Reason Code 09		The diagnosis is inconsistent with the patient's age.
Reason Code 10		The diagnosis is inconsistent with the patient's gender.
Reason Code 11		The diagnosis is inconsistent with the procedure.
Reason Code 12		The diagnosis is inconsistent with the provider type.
Reason Code 13		The date of death precedes the date of service.
Reason Code 14		The date of birth follows the date of service.
Reason Code 15		Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
Reason Code 16		Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
Reason Code 16	**M124**	Item billed does not have base equipment on file. Main equipment is missing therefore Medicare will not pay for supplies
Reason Code 16	**MA13 N264 N575**	Item(s) billed did not have a valid ordering physician name
Reason Code 16	**MA13 N265 N276**	Item(s) billed did not have a valid ordering physician National Provider Identifier (NPI) registered in
Reason Code 16	**MA27 N382**	Claim/service lacks information or has submission/billing error(s) Missing/incomplete/invalid Information
Reason Code 16	**MA83**	Claim/service lacks information or has submission/billing error(s). Did not indicate whether we are the primary or secondary payer.

Reason Code	Remark Code	Reason for Denial
Reason Code 17		Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate.
Reason Code 18		Duplicate claim/service.
Reason Code 19		Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
Reason Code 20		Claim denied because this injury/illness is covered by the liability carrier.
Reason Code 21		Claim denied because this injury/illness is the liability of the no-fault carrier.
Reason Code 22		Payment adjusted because this care may be covered by another payer per coordination of benefits.
Reason Code 23		Payment adjusted because charges have been paid by another payer.
Reason Code 24		Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
Reason Code 25		Payment denied. Your stop loss deductible has not been met.
Reason Code 26		Expenses incurred prior to coverage.
Reason Code 27		Expenses incurred after coverage terminated.
Reason Code 28		Coverage not in effect at the time the service was provided.
Reason Code 29	N211	The time limit for filing has expired. You may not appeal this decision.
Reason Code 30		Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
Reason Code 31		Claim denied as patient cannot be identified as our insured.
Reason Code 32		Our records indicate that this dependent is not an eligible dependent as defined.
Reason Code 33		Claim denied. Insured has no dependent coverage.
Reason Code 34		Claim denied. Insured has no coverage for newborns.
Reason Code 35		Benefit maximum has been reached.
Reason Code 36		Balance does not exceed co-payment amount.
Reason Code 37		Balance does not exceed deductible.
Reason Code 38		Services not provided or authorized by designated (network) providers.
Reason Code 39		Services denied at the time authorization/pre-certification was requested.
Reason Code 40		Charges do not meet qualifications for emergent/urgent care.

Reason Code	Remark Code	Reason for Denial
Reason Code 41		Discount agreed to in Preferred Provider contract.
Reason Code 42		Charges exceed our fee schedule or maximum allowable amount.
Reason Code 43		Gramm-Rudman reduction.
Reason Code 44		Prompt-pay discount.
Reason Code 45		Charges exceed your contracted/legislated fee arrangement.
Reason Code 46		This (these) service(s) is (are) not covered.
Reason Code 47		This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
Reason Code 48		This (these) procedure(s) is (are) not covered.
Reason Code 49		These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
Reason Code 50		These are non-covered services because this is not deemed a “medical necessity” by the payer.
Reason Code 50	**M127**	Documentation requested was not received or was not received timely
Reason Code 50	**N115**	Item billed may require a specific diagnosis or modifier code based on related Local Coverage Determination (LCD) Development letter requesting additional documentation to support service billed was not received within provided timeline Item being billed does not meet medical necessity
Reason Code 50	**N130**	Non covered services
Reason Code 50	**N180**	These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. This item or service does not meet the criteria for the category under which it was billed.
Reason Code 51		These are non-covered services because this is a pre-existing condition. Item being billed does not meet medical necessity.
Reason Code 52		The referring/prescribing provider is not eligible to refer/prescribe/order/perform the service billed.
Reason Code 53		Services by an immediate relative or a member of the same household are not covered.
Reason Code 54		Multiple physicians/assistants are not covered in this case.
Reason Code 55		Claim/service denied because procedure/ treatment is deemed experimental/ investigational by the payer.
Reason Code 56		Claim/service denied because procedure/ treatment has been deemed “proven to be effective” by the payer.

Reason Code	Remark Code	Reason for Denial
Reason Code 57		Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
Reason Code 58		Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
Reason Code 59		Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.
Reason Code 60		Charges for outpatient services with this proximity to inpatient services are not covered.
Reason Code 61		Charges adjusted as penalty for failure to obtain second surgical opinion.
Reason Code 62		Payment denied/reduced for absence of, or exceeded, precertification/ authorization.
Reason Code 63		Correction to a prior claim.
Reason Code 64		Denial reversed per Medical Review.
Reason Code 65		Procedure code was incorrect. This payment reflects the correct code.
Reason Code 66		Blood deductible.
Reason Code 67		Lifetime reserve days.
Reason Code 68		DRG weight.
Reason Code 69		Day outlier amount.
Reason Code 70		Cost outlier. Adjustment to compensate for additional costs.
Reason Code 71		Primary payer amount.
Reason Code 72		Coinsurance day.
Reason Code 73		Administrative days.
Reason Code 74		Indirect Medical Education Adjustment.
Reason Code 75		Direct Medical Education Adjustment.
Reason Code 76		Disproportionate Share Adjustment.
Reason Code 77		Covered days.
Reason Code 78		Non-covered days/Room charge adjustment.
Reason Code 79		Cost report days.
Reason Code 80		Outlier days.
Reason Code 81		Discharges.
Reason Code 82		PIP days.
Reason Code 83		Total visits.
Reason Code 84		Capital Adjustment.

Reason Code	Remark Code	Reason for Denial
Reason Code 85		Interest amount.
Reason Code 86		Statutory Adjustment.
Reason Code 87		Transfer amount.
Reason Code 88		Adjustment amount represents collection against receivable created in prior overpayment.
Reason Code 89		Professional fees removed from charges.
Reason Code 90		Ingredient cost adjustment.
Reason Code 91		Dispensing fee adjustment.
Reason Code 92		Claim paid in full.
Reason Code 93		No claim level adjustments.
Reason Code 94		Processed in excess of charges.
Reason Code 95		Benefits adjusted. Plan procedures not followed.
Reason Code 96		Non-covered charges.
Reason Code 97		Payment is included in the allowance for another service/procedure.
Reason Code 97	**M2**	Beneficiary was inpatient on date of service billed
Reason Code 97	**N390**	HCPCS code billed is included in the payment/allowance for another service/procedure that has already been adjudicated
Reason Code 98		The hospital must file the Medicare claim for this inpatient non-physician service.
Reason Code 99		Medicare Secondary Payer Adjustment amount.
Reason Code 100		Payment made to patient/insured/responsible party.
Reason Code 101		Predetermination. Anticipated payment upon completion of services or claim adjudication.
Reason Code 102		Major Medical Adjustment.
Reason Code 103		Provider promotional discount (e.g., Senior citizen discount).
Reason Code 104		Managed care withholding.
Reason Code 105		Tax withholding.
Reason Code 106		Patient payment option/election not in effect.
Reason Code 107		Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
Reason Code 108		Payment adjusted because rent/purchase guidelines were not met.
Reason Code 108	**N130**	Rent/purchase guidelines were not met. Consult plan benefit documents/guidelines for information about restrictions for this service.

Reason Code	Remark Code	Reason for Denial
Reason Code 109		Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Reason Code 109	N104	Claim was submitted to incorrect Jurisdiction
Reason Code 109	N130	Claim was submitted to incorrect contractor
Reason Code 109	N418	Claim was billed to the incorrect contractor Beneficiary was enrolled in a Medicare Health Maintenance Organization (HMO) for date of service submitted
Reason Code 110		Billing date predates service date.
Reason Code 111		Not covered unless the provider accepts assignment.
Reason Code 112		Payment adjusted as not furnished directly to the patient and/or not documented.
Reason Code 113		Payment denied because service/procedure was provided outside the United States or as a result of war.
Reason Code 114		Procedure/product not approved by the Food and Drug Administration.
Reason Code 115		Payment adjusted as procedure postponed or cancelled.
Reason Code 116		Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
Reason Code 117		Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
Reason Code 118		Charges reduced for ESRD network support.
Reason Code 119		Benefit maximum for this time period has been reached.
Reason Code 120		Patient is covered by a managed care plan.
Reason Code 121		Indemnification adjustment.
Reason Code 122		Psychiatric reduction.
Reason Code 123		Payer refund due to overpayment.
Reason Code 124		Payer refund amount – not our patient.
Reason Code 125		Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
Reason Code 126		Deductible – Major Medical.
Reason Code 127		Coinsurance – Major Medical.
Reason Code 128		Newborn’s services are covered in the mother’s allowance.

Reason Code	Remark Code	Reason for Denial
Reason Code 129		Payment denied. Prior processing information appears incorrect.
Reason Code 130		Claim submission fee.
Reason Code 131		Claim specific negotiated discount.
Reason Code 132		Prearranged demonstration project adjustment.
Reason Code 133		The disposition of this claim/service is pending further review.
Reason Code 134		Technical fees removed from charges.
Reason Code 135		Claim denied. Interim bills cannot be processed.
Reason Code 136		Claim adjusted. Plan procedures of a prior payer were not followed.
Reason Code 137		Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
Reason Code 138		Claim/Service denied. Appeal procedures not followed or time limits not met.
Reason Code 139		Contracted funding agreement. Subscriber is employed by the provider of the services.
Reason Code 140		Patient/Insured health identification number and name do not match.
Reason Code 141		Claim adjustment because the claim spans eligible and ineligible periods of coverage.
Reason Code 142		Claim adjusted by the monthly Medicaid patient liability amount.
Reason Code 143		Portion of payment deferred.
Reason Code 144		Incentive adjustment, e.g., preferred product/service.
Reason Code 145		Premium payment withholding.
Reason Code 146		Payment denied because the diagnosis was invalid for the date(s) of service reported.
Reason Code 147		Provider contracted/negotiated rate expired or not on file.
Reason Code 148		Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
Reason Code A0		Patient refund amount.
Reason Code A1		Claim denied charges.
Reason Code A1	**N370**	Oxygen equipment has exceeded the number of approved paid rentals
Reason Code A2		Contractual adjustment.
Reason Code A3		Medicare Secondary Payer liability met.
Reason Code A4		Medicare Claim PPS Capital Day Outlier Amount.
Reason Code A5		Medicare Claim PPS Capital Cost Outlier Amount.
Reason Code A6		Prior hospitalization or 30 day transfer requirement not met.

Reason Code	Remark Code	Reason for Denial
Reason Code A7		Presumptive Payment Adjustment.
Reason Code A8		Claim denied; ungroupable DRG.
Reason Code B1		Non-covered visits.
Reason Code B2		Covered visits.
Reason Code B3		Covered charges.
Reason Code B4		Late filing penalty.
Reason Code B5		Payment adjusted because coverage/program guidelines were not met or were exceeded.
Reason Code 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.
Reason Code B7		This provider was not certified/eligible to be paid for this procedure/service on this date of service.
Reason Code B7	**N570**	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Missing/incomplete/invalid credentialing data.
Reason Code B8		Claim/service not covered/reduced because alternative services were available, and should not have been utilized.
Reason Code B9		Services not covered because the patient is enrolled in a Hospice.
Reason Code 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.
Reason Code B11		The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
Reason Code B12		Services not documented in patient's medical records.
Reason Code B13		Previously paid. Payment for this claim/service may have been provided in a previous payment.
Reason Code B14		Payment denied because only one visit or consultation per physician per day is covered.
Reason Code B15		Payment adjusted because this service/procedure is not paid separately.
Reason Code B16		Payment adjusted because "new patient" qualifications were not met.
Reason Code B17		Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
Reason Code B18		Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.

Reason Code	Remark Code	Reason for Denial
Reason Code B18	N522	Duplicate claim has already been submitted and processed
Reason Code B19		Claim/service adjusted because of the finding of a Review Organization.
Reason Code B20		Payment adjusted because procedure/service was partially or fully furnished by another provider.
Reason Code B20	M115 N211	Procedure/service was partially or fully furnished by another provider. This item is denied when provided to this patient by a non-contract or non- demonstration supplier.
Reason Code B21		The charges were reduced because the service/care was partially furnished by another physician.
Reason Code B22		This payment is adjusted based on the diagnosis.
Reason Code B23		Payment denied because this provider has failed an aspect of a proficiency testing program.
Reason Code D1		Claim/service denied. Level of subluxation is missing or inadequate.
Reason Code D2		Claim lacks the name, strength, or dosage of the drug furnished.
Reason Code D3		Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
Reason Code D4		Claim/service does not indicate the period of time for which this will be needed.
Reason Code D5		Claim/service denied. Claim lacks individual lab codes included in the test.
Reason Code D6		Claim/service denied. Claim did not include patient's medical record for the service.
Reason Code D7		Claim/service denied. Claim lacks date of patient's most recent physician visit.
Reason Code D8		Claim/service denied. Claim lacks indicator that "x-ray is available for review".
Reason Code D9		Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
Reason Code D10		Claim/service denied. Completed physician financial relationship form not on file.
Reason Code D11		Claim lacks completed pacemaker registration form.
Reason Code D12		Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
Reason Code D13		Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
Reason Code D14		Claim lacks indication that plan of treatment is on file.
Reason Code D15		Claim lacks indication that service was supervised or evaluated by a physician.
Reason Code W1		Workers Compensation State Fee Schedule Adjustment.