

		MHC ADJUSTMENT CODE		HIPAA ADJUSTMENT TRANSLATION	REMITTANCE ADVICE REMARKS
Status	Code	Description	Code	Description	
Reversal	A1	ADJUSTMENT TO RECOVER PREV.PAYMENT	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A10	AUTHORIZED LIABILITY	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A11	ADDITL. FORMS RECEIVED, REPROCESSED	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Inactive	A12	DONT USE-APPEALDENIED-MEDREC INSUFF	95	Benefits adjusted. Plan procedures not followed.	
Inactive	A13	DONT USE-APPEALDENIED ER CRIT NOT	95	Benefits adjusted. Plan procedures not followed.	
Reversal	A14	CHECK RETURNED/REFUND;CLAIM REPROC.	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A15	REFERRAL FOUND AFTER ADD'L REVIEW	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A16	CLAIM REVERSED FOR EDITING	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A17	SEE MEMBER ID#-PLEASE UPDATE RECORD	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A18	ADJ-REFLECTS COST OUTLIER	70	Cost outlier - Adjustment to compensate for additional costs.	
Reversal	A19	ADJ-HOSP READMISSION WITHIN 30 DAYS	A6	Prior hospitalization or 30 day transfer requirement not met.	
Reversal	A2	ADMINISTRATIVE/MEDICAL ADJUSTMENT	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A20	ADJ-REFLECTS DAY OUTLIER	69	Day outlier amount.	
Reversal	A21	ADJ-DRG PYMNT DUE TO HOSP TRANSFER	87	Transfer amount.	
Reversal	A3	APPEAL-DENIAL OVERTURNED	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A4	APPEAL-DENIAL UPHELD	138	Claim/service denied. Appeal procedures not followed or time limits not met.	
Reversal	A5	APPEAL-PAYMENT UPHELD	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A6	CLAIM PROCESSING ERROR - CORRECTED	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A7	INCORRECT QUANTITY-CLAIM CORRECTED	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A8	EMERGENT DIAGNOSIS	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Reversal	A9	AUTHORIZED EMERGENCY ROOM VISIT	88	Adjustment amount represents collection against receivable created in prior overpayment. Note: Inactive for 004050.	
Inactive	AGE	DONT USE4/2/2001-AGE CODE REPLACE	95	Benefits adjusted. Plan procedures not followed.	
Inactive	ASP	DONT USE4/2/2001 ASST SURG PYMNT	95	Benefits adjusted. Plan procedures not followed.	
Claim Check	C10	DEFAULT CLAIM LINE DENIAL	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	RPLCED FOR INTENSITY OF SVC VS DX	B22	This payment is adjusted based on the diagnosis.	
Claim Check	C12	MULTIPLE PROCEDURE PLAN LIMIT	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	
Claim Check	C13	MEDICAL VISIT NO PAYMENT	B15	Payment adjusted because this procedure/service is not paid separately.	
Claim Check	C14	INCIDENTAL PROCEDURE NO PAYMENT	B15	Payment adjusted because this procedure/service is not paid separately.	

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Claim Check	C15	MUTUALLY EXCLUSIVE PROCEDURES	B15	Payment adjusted because this procedure/service is not paid separately.	
Claim Check	C16	REBUNDLING OF CODES	B15	Payment adjusted because this procedure/service is not paid separately.	
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	Payment adjusted because this procedure/service is not paid separately.	
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 NOT REQUIRED	54	Multiple physicians/assistants are not covered in this case .	
Claim Check	CC2	REPLACED NEW VISIT WITH ESTABLISHED	B16	Payment adjusted because `New Patient` qualifications were not met.	
Claim Check	CC4	DENIED WITHIN SURGERY POST OP RANGE	97	Payment is included in the allowance for another service/procedure.	
Claim Check	CC5	DENIED-WITHIN SURGERY PRE-OP RANGE	97	Payment is included in the allowance for another service/procedure.	
Claim Check	CC6	DUPLICATE PROCEDURE PERFORMED	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	
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	Payment is included in the allowance for another service/procedure.	
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.	
Inactive	COR	CODING CORRECTIONS/REPLACEMENT	95	Benefits adjusted. Plan procedures not followed.	
Denial	D1	REJECTED-MEDICAL RECORDS REQUIRED	16 + M127	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M127 - Missing/incomplete/invalid patient medical record for this service.
Denial	D10	REJECTED-EXCEEDS MAX.FILING TIME	29	The time limit for filing has expired.	
Denial	D11	REJECTED-PRIMARY CARRIER EOB REQ.	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	
Denial	D12	DENIED-MVA-AUTO INSURER IS PRIMARY	21	Claim denied because this injury/illness is the liability of the no-fault carrier.	
Denial	D13	DENIED-WORKER'S COMP IS PRIMARY	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	
Denial	D14	REJECTED-CLAIM & EOB MUST MATCH	17 + N48	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N48 - Claim information does not agree with information received from other insurance carrier.
Denial	D15	FAMILY PLANNG; RESUBMIT TO KEYSTONE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
Denial	D16	REJECTED-RESUBMIT TO CLARITY VISION	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
Denial	D17	REJECTED-RESUBMIT TO PAID PRESC.INC	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
Denial	D18	DENIED-OTHR SVCS INC W/PRIMARY SVCS	97	Payment is included in the allowance for another service/procedure.	
Denial	D19	DENIED-NON-COVERED SERVICE	96	Non-covered charge(s).	
Denial	D2	DENIED-NOT MEMBER'S CAP.PROVIDER	38	Services not provided or authorized by designated (network) providers.	
Denial	D20	DENIED-OVER MAX PROC/BENEFIT LIMIT	119	Benefit maximum for this time period has been reached.	
Denial	D21	REJECTED-NO REFERRAL/INVALID/EXPIRE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	
Denial	D22	REJECTED-NO/INVALID/EXPIRED PRECERT	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	
Denial	D23	DENIED-SAME SVC PD TO DIFF PROVIDER	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	

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Denial	D24	REJECTED-RLTD MATERNITY CLM NOT RCV	148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	
Denial	D25	DENIED-DUP CLM PD/DENIED PREVIOUSLY	18	Duplicate claim/service.	
Denial	D26	DUPLICATE CLAIM - ORIG UNDER REVIEW	18	Duplicate claim/service.	
Denial	D27	SUBMIT BILL TO M.A. 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	17 + M58	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M58 - Missing/incomplete/invalid claim information. Resubmit claim after corrections.
Denial	D29	EMERGENCY RM VISIT NOT APPROVED	40	Charges do not meet qualifications for emergent/urgent care.	
Denial	D3	REJECTED-AGE DISCREPANCY WITH PROCEDURE CODE BILLED; REFILE	6	The procedure/revenue code is inconsistent with the patient's age.	
Denial	D30	REJECTED-FORM NOT ATTACHED	17 + M58	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M58 - Missing/incomplete/invalid claim information. Resubmit claim after corrections.
Denial	D31	REJECTED-EPSDT FORM NOT SUBMITTED	17 + M58	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M58 - Missing/incomplete/invalid claim information. Resubmit claim after corrections.
Denial	D32	DENIED-PRIOR PMTS EQUAL PURCHASE AMT	108	Payment adjusted because rent/purchase guidelines were not met.	
Denial	D33	REJECTED-CHGS NOT SUBMITTED ON BILL	16 + M54	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54 - Missing/incomplete/invalid total charges.
Denial	D34	ITEMIZE PAYMENTS BY CODE ON THE EOB	17 + N48	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N48 - Claim information does not agree with information received from other insurance carrier.
Denial	D35	REJ-SUBMITD BILL DOESN'T MATCH AUTH	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	
Denial	D36	REJECTED-DSCRPNCY IN LVL CARE WAUTH	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	
Denial	D37	REJECTED-USE M.A. PROC CDE FOR AMB	5	The procedure code/bill type is inconsistent with the place of service.	
Denial	D38	BABY NOT ENROLLED; REBILL W/BABY ID	32	Our records indicate that this dependent is not an eligible dependent as defined.	
Denial	D39	REJECTED-REFILE WITH GHP MEMBER ID	31	Claim denied as patient cannot be identified as our insured.	
Denial	D4	REJECTED-INVALID MODIFIER;REFILE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	
Denial	D40	DENIED-ANESTHESIA MINUTES REPORTED INCORRECTLY; ;RESUBMIT IN QUANTITY FIELD	16	Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	
Inactive	D41	DONT USE - INFORMAL REVIEW DENIAL	95	Benefits adjusted. Plan procedures not followed.	
Inactive	D42	DONT USE-NPAR INFORMAL REVIEW DENY	95	Benefits adjusted. Plan procedures not followed.	
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 COUNTY BH PROVIDER	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
Denial	D45	MEDICAL SERVICES NOT APPROVED	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	
Denial	D46	MEDICAL RECORDS ARE INSUFFICIENT	B12	Services not documented in patients' medical records.	

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Denial	D47	REJECTED-PVR NMBR & TIN DON'T MATCH	125 + MA1	125 - Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA113 - Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
Denial	D48	DENIED-DX NOT CONSISTENT W/MED REV	11	The diagnosis is inconsistent with the procedure.	
Denial	D49	MERCK CREDIT	144	Incentive adjustment, e.g. preferred product/service.	
Denial	D5	REJECTED-INVALID PROCEDURE CODE;REFILE W/IN 90 DAYS OF RA	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	
Denial	D50	DENIED FOR MULTIPLE REASONS	A1	Claim denied charges.	
Denial	D51	DENIED-SVCS BILLED UNDER NEWBORN #	140	Patient/Insured health identification number and name do not match.	
Denial	D52	DENIED-SVCS NOT PD TIL CONFINE ENDS	135	Claim denied. Interim bills cannot be processed.	
Denial	D53	LAB NOT AUTHD/PERFMD BY NCAP'D PROV	38	Services not provided or authorized by designated (network) providers.	
Denial	D54	DENY-NO REFERRAL AFTER 1ST/2ND REV	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	
Denial	D55	CLAIMS COMBINED FOR EDITING	B15	Payment adjusted because this procedure/service is not paid separately.	
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.	
Denial	D57	REJECTED-DRG CODE REQUIRED	A8	Claim denied; ungroupable DRG	
Denial	D58	DENY-ADMINISTRATIVE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	
Denial	D59	RETRO-DISENROLLMENT-SUBMIT TO MA	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	
Denial	D6	REJECTED-ITEM.BILL W/DOS REQUIRED	151	Payment adjusted because the payer deems the information submitted does not support this many services.	
Denial	D60	SUBMIT NDC CODE, NAME, DOSAGE, QTY	16 + N60	16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N60 - A valid NDC is required for payment of drug claims effective October 02.
Denial	D61	PROCEDURES FOR BILLING W/GROUP,REFERRING,PERFORMING PROVIDER WERE NOT FOLLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	
Denial	D62	REJECTED-SEX DISCREPANCY WITH PROCEDURE CODE BILLED; REFILE	7	The procedure/revenue code is inconsistent with the patient's gender.	
Denial	D63	REJECTED-EXPENSES INCURRED PRIOR TO COVERAGE	26	Expenses incurred prior to coverage.	
Denial	D65	DENIED - PAPER UB FORMS CANNOT BE PROCESSED UNLESS A VALID TYPE OF BILL IS SUBMITTED IN FIELD 4; RESUBMIT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	
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. Additional information is supplied using remittance advice remarks codes whenever appropriate.	
Denial	D67	DENIED - INFERTILITY SERVICES NOT COVERED BY MA OR GATEWAY	96	Non-covered charge(s).	
Denial	D68	DENIED - RENAL DIALYSIS SERVICES ARE NOT A PART OF YOUR BENEFIT PACKAGE UNDER MA OR GATEWAY	96	Non-covered charge(s).	
Denial	D7	REJECTED-INVALID DIAGNOSIS CODE;REFILE W/IN 90 DAYS OF RA	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	
Denial	D8	REJECTED-EXPENSES INCURRED AFTER COVERAGE TERMINATED	27	Expenses incurred after coverage terminated.	
Denial	D9	DENIED-BENEFITS TERMINATED FOR DOS	39	Services denied at the time authorization/pre-certification was requested.	
Inactive	INC	INCIDENTAL PROCEDURE - NO PAYMENT	95	Benefits adjusted. Plan procedures not followed.	
Inactive	LIM	DAILY/LIFETIME LIMIT FOR CODE	95	Benefits adjusted. Plan procedures not followed.	
Inactive	ME	DONT USE 4/2/2001 MUTUALLY EXCLUSVE	95	Benefits adjusted. Plan procedures not followed.	

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Inactive	MPP	MULTIPLE PROCEDURE PAYMENT	95	Benefits adjusted. Plan procedures not followed.	
Informational	R1	CAPITATED SERVICE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	
Inactive	R10	NONCLEAN EDI-PROV/MBR # NOT SUBMIT	95	Benefits adjusted. 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	Interest amount.	
Informational	R13	PAYMENT REFLECTS MEDICARE COB	23	Payment adjusted because charges have been paid by another payer.	
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	R2	PAYMENT REFLECTS NON-MEDICARE COB	23	Payment adjusted because charges have been paid by another payer.	
Informational	R20	INVALID PLACE OF SERVICE-CODE MAY HAVE BEEN CORRECTED TO ALLOW PAYMENT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	
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	NEGOTIATED RATE	131	Claim specific negotiated discount.	
Informational	R6	REPROCESSED/CORRECT	125	125 - Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	
Informational	R7	PAID AT QUANTITY ALLOWED IN PRECERT	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	
Informational	R8	CLAIM RESOLUTION FINALIZED	A2	Contractual adjustment.	
Informational	R9	TPL 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.	
Inactive	REB	DONT USE 4/2/2001 REBUNDLNG OF CODE	95	Benefits adjusted. Plan procedures not followed.	
Inactive	VIS	DONT USE4/2/01 MEDICAL VISIT NO PAY	95	Benefits adjusted. Plan procedures not followed.	
ADDITIONAL SYSTEM GENERATED ADJUSTMENTS CODES					
			23	Payment adjusted because charges have been paid by another payer.	
			94	Processed in Excess of charges.	
			24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	
			94	Processed in Excess of charges.	
			97	Payment is included in the allowance for another service/procedure.	
			45	Charges exceed your contracted/ legislated fee arrangement.	
			42	Charges exceed our fee schedule or maximum allowable amount.	
			131	Claim specific negotiated discount.	
			104	Managed care withholding.	
			35	Lifetime benefit maximum has been reached.	
			1	Deductible Amount	
			2	Coinsurance Amount	
			3	Co-payment Amount	