EOB: Claims Adjustment Reason Codes List

What is a reason code used on an EOB?

Reason codes appear on an explanation of benefits (EOB) to communicate why a claim has been adjusted. If there is no adjustment to a claim/line, then there is no adjustment reason code.

The letters preceding the number codes identify: Contractual Obligation (CO), Correction or reversal to a prior decision (CR), and Patient Responsibility (PR).

Here is a comprehensive reason codes list:

Do you have reason code with you? Want to know what is the exact reason?

Just hold control key and press 'F'. Search box will appear then put your adjustment reason code in search box e.g. '**B10**' and click the NEXT button in the Search Box to locate the Adjustment Reason code you are inquiring on.

Adjustment Reason Codes:

Reason Code 1: The procedure code is inconsistent with the modifier used or a required

modifier is missing.

Reason Code 2: The procedure code/bill type is inconsistent with the place of service.

Reason Code 3: The procedure/revenue code is inconsistent with the patient's age.

Reason Code 4: The procedure/revenue code is inconsistent with the patient's gender.

Reason Code 5: The procedure code is inconsistent with the provider type/specialty (taxonomy).

Reason Code 6: The diagnosis is inconsistent with the patient's age.

Reason Code 7: The diagnosis is inconsistent with the patient's gender.

Reason Code 8: The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 9: 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.

Reason Code 10: The date of death precedes the date of service.

Reason Code 11: The date of birth follows the date of service.

Reason Code 12: The authorization number is missing, invalid, or does not apply to the billed services or provider.

Reason Code 13: 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.)

Reason Code 14: Requested information 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.)

Reason Code 15: Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service

Reason Code 16: This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

Reason Code 17: This injury/illness is covered by the liability carrier.

Reason Code 18: This injury/illness is the liability of the no-fault carrier.

Reason Code 19: This care may be covered by another payer per coordination of benefits.

Reason Code 20: The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

Reason Code 21: Charges are covered under a capitation agreement/managed care plan.

Reason Code 22: Payment denied. Your Stop loss deductible has not been met.

Reason Code 23: Expenses incurred prior to coverage.

Reason Code 24: Expenses incurred after coverage terminated.

Reason Code 25: Coverage not in effect at the time the service was provided.

Reason Code 26: The time limit for filing has expired.

Reason Code 27: Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

Reason Code 28: Patient cannot be identified as our insured.

Reason Code 29: Our records indicate that this dependent is not an eligible dependent as defined.

Reason Code 30: Insured has no dependent coverage.

Reason Code 31: Insured has no coverage for new borns.

Reason Code 32: Lifetime benefit maximum has been reached.

Reason Code 33: Balance does not exceed co-payment amount.

Reason Code 34: Balance does not exceed deductible.

Reason Code 35: Services not provided or authorized by designated (network/primary care) providers.

Reason Code 36: Services denied at the time authorization/pre-certification was requested.

Reason Code 37: 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.

Reason Code 38: Discount agreed to in Preferred Provider contract.

Reason Code 39: Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)

Reason Code 40: Gramm-Rudman reduction.

Reason Code 41: Prompt-pay discount.

Reason Code 42: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Reason Code 43: This (these) service(s) is (are) not covered.

Reason Code 44: This (these) diagnosis (es) is (are) not covered, missing, or are invalid.

Reason Code 45: This (these) procedure(s) is (are) not covered.

Reason Code 46: 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.

Reason Code 47: 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.

Reason Code 48: These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 49: The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Reason Code 50: Services by an immediate relative or a member of the same household are not covered.

Reason Code 51: 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.

Reason Code 52: Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 53: Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 54: Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many service, this length of service, this dosage, or this day's supply.

Reason Code 55: 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.

Reason Code 56: 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.

Reason Code 57: Charges for outpatient services are not covered when performed within a period of time prior to orafter inpatient services.

Reason Code 58: Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if

present.

Reason Code 59: Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Reason Code 60: Correction to a prior claim.

Reason Code 61: Denial reversed per Medical Review.

Reason Code 62: Procedure code was incorrect. This payment reflects the correct code.

Reason Code 63: Blood Deductible.

Reason Code 64: Lifetime reserve days. (Handled in QTY, QTY01=LA)

Reason Code 65: DRG weight. (Handled in CLP12)

Reason Code 66: Day outlier amount.

Reason Code 67: Cost outlier - Adjustment to compensate for additional costs.

Reason Code 68: Primary Payer amount.

Reason Code 69: Coinsurance day. (Handled in QTY, QTY01=CD)

Reason Code 70: Administrative days.

Reason Code 71: Indirect Medical Education Adjustment.

Reason Code 72: Direct Medical Education Adjustment.

Reason Code 73: Disproportionate Share Adjustment.

Reason Code 74: Covered days. (Handled in QTY, QTY01=CA)

Reason Code 75: Non-Covered days/Room charge adjustment.

Reason Code 76: Cost Report days. (Handled in MIA15)

Reason Code 77: Outlier days. (Handled in QTY, QTY01=OU)

Reason Code 78: Discharges.

Reason Code 79: PIP days.

Reason Code 80: Total visits.

Reason Code 81: Capital Adjustment. (Handled in MIA)

Reason Code 82: Patient Interest Adjustment (Use Only Group code PR)

Reason Code 83: Statutory Adjustment.

Reason Code 84: Transfer amount.

Reason Code 85: Adjustment amount represents collection against receivable created in prior overpayment.

Reason Code 86: Professional fees removed from charges.

Reason Code 87: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.

Reason Code 88: Dispensing fee adjustment.

Reason Code 89: Claim Paid in full.

Reason Code 90: No Claim level Adjustments.

Reason Code 91: Processed in Excess of charges.

Reason Code 92: Plan procedures not followed.

Reason Code 93: 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.

Reason Code 94: 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.

Reason Code 95: The hospital must file the Medicare claim for this inpatient non-physician service.

Reason Code 96: Medicare Secondary Payer Adjustment Amount.

Reason Code 97: Payment made to patient/insured/responsible party/employer.

Reason Code 98: Predetermination: anticipated payment upon completion of services or claim adjudication.

Reason Code 99: Major Medical Adjustment.

Reason Code 100: Provider promotional discount (e.g., Senior citizen discount).

Reason Code 101: Managed care withholding.

Reason Code 102: Tax withholding.

Reason Code 103: Patient payment option/election not in effect.

Reason Code 104: The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 105: Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 106: Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

Reason Code 107: Billing date predates service date.

Reason Code 108: Not covered unless the provider accepts assignment.

Reason Code 109: Service not furnished directly to the patient and/or not documented.

Reason Code 110: Payment denied because service/procedure was provided outside the United States or as a result of war.

Reason Code 111: Procedure/product not approved by the Food and Drug Administration.

Reason Code 112: Procedure postponed, canceled, or delayed.

Reason Code 113: The advance indemnification notice signed by the patient did not comply with requirements.

Reason Code 114: Transportation is only covered to the closest facility that can provide the necessary care.

Reason Code 115: ESRD network support adjustment.

Reason Code 116: Benefit maximum for this time period or occurrence has been reached.

Reason Code 117: Patient is covered by a managed care plan.

Reason Code 118: Indemnification adjustment - compensation for outstanding member responsibility.

Reason Code 119: Psychiatric reduction.

Reason Code 120: Payer refund due to overpayment.

Reason Code 121: Payer refund amount - not our patient.

Reason Code 122: 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.)

Reason Code 123: Deductible -- Major Medical

Reason Code 124: Coinsurance -- Major Medical

Reason Code 125: New born's services are covered in the mother's Allowance.

Reason Code 126: Prior processing information appears incorrect. 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.)

Reason Code 127: Claim submission fee.

Reason Code 128: Claim specific negotiated discount.

Reason Code 129: Prearranged demonstration project adjustment.

Reason Code 130: The disposition of the claim/service 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).

Reason Code 131: Technical fees removed from charges.

Reason Code 132: Interim bills cannot be processed.

Reason Code 133: Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)

Reason Code 134: Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

Reason Code 135: Appeal procedures not followed or time limits not met.

Reason Code 136: Contracted funding agreement - Subscriber is employed by the provider of services.

Reason Code 137: Patient/Insured health identification number and name do not match.

Reason Code 138: Claim spans eligible and ineligible periods of coverage.

Reason Code 139: Monthly Medicaid patient liability amount.

Reason Code 140: Portion of payment deferred.

Reason Code 141: Incentive adjustment, e.g. preferred product/service.

Reason Code 142: Premium payment withholding

Reason Code 143: Diagnosis was invalid for the date(s) of service reported.

Reason Code 144: Provider contracted/negotiated rate expired or not on file.

Reason Code 145: 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.)

Reason Code 146: Lifetime benefit maximum has been reached for this service/benefit category.

Reason Code 147: Payer deems the information submitted does not support this level of service.

Reason Code 148: Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

Reason Code 149: 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.

Reason Code 150: Payer deems the information submitted does not support this dosage.

Reason Code 151: Payer deems the information submitted does not support this day's supply.

Reason Code 152: Patient refused the service/procedure.

Reason Code 153: Flexible spending account payments. Note: Use code 187.

Reason Code 154: Service/procedure was provided as a result of an act of war.

Reason Code 155: Service/procedure was provided outside of the United States.

Reason Code 156: Service/procedure was provided as a result of terrorism.

Reason Code 157: Injury/illness was the result of an activity that is a benefit exclusion.

Reason Code 158: Provider performance bonus

Reason Code 159: State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.

Reason Code 160: Attachment referenced on the claim was not received.

Reason Code 161: Attachment referenced on the claim was not received in a timely fashion.

Reason Code 162: Referral absent or exceeded.

Reason Code 163: These services were submitted after this payer's responsibility for processing claims under this plan ended.

Reason Code 164: 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.

Reason Code 165: Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.

Reason Code 166: Alternate benefit has been provided.

Reason Code 167: 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.

Reason Code 168: 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.

Reason Code 169: 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.

Reason Code 170: Service was not prescribed by a physician. This change effective 7/1/2013: Service/equipment was not prescribed by a physician.

Reason Code 171: Service was not prescribed prior to delivery.

Reason Code 172: Prescription is incomplete.

Reason Code 173: Prescription is not current.

Reason Code 174: Patient has not met the required eligibility requirements.

Reason Code 175: Patient has not met the required spend down requirements.

Reason Code 176: 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.

Reason Code 177: Patient has not met the required residency requirements.

Reason Code 178: Procedure code was invalid on the date of service.

Reason Code 179: Procedure modifier was invalid on the date of service.

Reason Code 180: 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.

Reason Code 181: 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.

Reason Code 182: 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.

Reason Code 183: Level of care change adjustment.

Reason Code 184: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)

Reason Code 185: This product/procedure is only covered when used according to FDA recommendations.

Reason Code 186: 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service

Reason Code 187: Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.

Reason Code 188: Not a work related injury/illness and thus not the liability of the workers' compensation carrier 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 regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

Reason Code 189: 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.

Reason Code 190: Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Reason Code 191: Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.

Reason Code 192: Refund issued to an erroneous priority payer for this claim/service.

Reason Code 193: Claim/service denied based on prior payer's coverage determination.

Reason Code 194: Precertification/authorization/notification absent.

Reason Code 195: Precertification/authorization exceeded.

Reason Code 196: Revenue code and Procedure code do not match.

Reason Code 197: Expenses incurred during lapse in coverage

Reason Code 198: Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least on remark code must be provider (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an alert.)

Reason Code 199: Non-covered personal comfort or convenience services.

Reason Code 200: Discontinued or reduced service.

Reason Code 201: This service/equipment/drug is not covered under the patient's current benefit plan

Reason Code 202: Pharmacy discount card processing fee

Reason Code 203: National Provider Identifier - missing.

Reason Code 204: National Provider identifier - Invalid format

Reason Code 205: National Provider Identifier - Not matched.

Reason Code 206: 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) This change effective 7/1/2013: 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 only with Group code OA)

Reason Code 207: Payment adjusted because pre-certification/authorization not received in a timely fashion

Reason Code 208: National Drug Codes (NDC) not eligible for rebate, are not covered.

Reason Code 209: Administrative surcharges are not covered

Reason Code 210: Non-compliance with the physician self-referral prohibition legislation or payer policy.

Reason Code 211: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. 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 regulation.

If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.

Reason Code 212: Based on subrogation of a third-party settlement

Reason Code 213: Based on the findings of a review organization

Reason Code 214: Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)

Reason Code 215: Based on entitlement to benefits. 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 regulation.

If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.

Reason Code 216: 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 regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).

Reason Code 217: The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)

Reason Code 218: Workers' Compensation claim is under investigation. 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 regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation.

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 regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property& Casualty only)

Reason Code 219: 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.

Reason Code 220: Adjustment code for 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.

Reason Code 221: Patient identification compromised by identity theft. Identity verification required for processing this and future claims.

Reason Code 222: Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)

Reason Code 223: 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.)

This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely 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.)

Reason Code 224: 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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Reason Code 225: Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication

Reason Code 226: 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.

This change effective 7/1/2013: 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 only with Group Code PR)

Reason Code 227: No available or correlating CPT/HCPCS code to describe this service. Note:

Used only by Property and Casualty.

Reason Code 228: 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.

Reason Code 229: Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.

Reason Code 230: Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.

Reason Code 231: 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.)

Reason Code 232: Sales Tax

Reason Code 233: 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. This change effective 7/1/2013: 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 compensation state regulations/ fee schedule requirements.

Reason Code 234: 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.)

Reason Code 235: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)

Reason Code 236: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.

Reason Code 237: The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Reason Code 238: Low Income Subsidy (LIS) Co-payment Amount

Reason Code 239: Services not provided by network/primary care providers.

Reason Code 240: Services not authorized by network/primary care providers.

Reason Code 241: Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.

Reason Code 242: Provider performance program withhold.

Reason Code 243: This non-payable code is for required reporting only.

Reason Code 244: Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.

Reason Code 245: Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.

Reason Code 246: This claim has been identified as a resubmission. (Use only with Group Code CO)

Reason Code 247: The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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.

Reason Code 248: 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).

Reason Code 249: An attachment 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).

Reason Code 250: Sequestration - reduction in federal payment

Reason Code 251: 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.

Reason Code 252: The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)

Reason Code 253: Service not payable per managed care contract.

Reason Code 254: 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 lace of premium payment). (Use only with Group Code OA)

Reason Code 255: Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.

Reason Code 256: Additional payment for Dental/Vision service utilization

Reason Code 257: Processed under Medicaid ACA Enhance Fee Schedule

Reason Code 258: The procedure or service is inconsistent with the patient's history.

Reason Code 259: Adjustment for delivery cost. Note: to be used for pharmaceuticals only.

Reason Code 260: Adjustment for shipping cost. Note: To be used for pharmaceuticals only.

Reason Code 261: Adjustment for postage cost. Note: To be used for pharmaceuticals only.

Reason Code 262: Adjustment for administrative cost. Note: To be used for pharmaceuticals only.

Reason Code 263: Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.

Reason Code 264: Claim/service spans multiple months. Rebill as a separate claim/service.

Reason Code 265: The Claim spans two calendar years. Please resubmit on claim per calendar

year.

Reason Code 266: Patient refund amount.

Reason Code 267: 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.)

Reason Code 268: Contractual adjustment.

Reason Code A0: Medicare Secondary Payer liability met.

Reason Code A1: Medicare Claim PPS Capital Day Outlier Amount.

Reason Code A2: Medicare Claim PPS Capital Cost Outlier Amount.

Reason Code A3: Prior hospitalization or 30-day transfer requirement not met.

Reason Code A4: Presumptive Payment Adjustment

Reason Code A5: Ungroupable DRG.

Reason Code A6: Non-covered visits.

Reason Code A7: 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 A8: Ungroupable DRG.

Reason Code B1: Non-covered visits.

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.

This reason code list will help you to identify the actual reason of adjustment or reduced payment. If the reason code is valid, you can pass the same information to patient for their responsibility of payment in the statement.

Using this comprehensive reason code list, you can correct and resubmit the claims to payer.