

# Appendix B

HCFA Reason, Remark and Value  
Codes and Messages for  
Provider Remittance Notices  
(ANSI and Standard Paper Remittance Advices)

July 1998 UPDATE

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**STANDARD CLAIM ADJUSTMENT (CAS) REASON CODES (6/98)**

Any reference to procedures or services in the Claim Adjustment Reason Codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs). An "\*" after a code value denotes that the code value is inactive as of release of version 3040 of the 835. An "`" after a code value denotes that the code value is inactive as of release of version 3050 of the 835. An "``" after a code value denotes that the code value is inactive as of the release of version 4010 of the 835. Codes with either of these symbols may not be used in post 3040, 3050 and/or 4010 versions of the 835 or versions of the NSF 2.0 or later.

This list supersedes earlier CAS reason code lists. The indicated wording may not be modified without approval of the X12 Claim Reason and Status Code Task Group. These codes were developed for use by all U.S. health payers. As result, they are generic, and there are a number of codes that do not apply to Medicare. These are the only CAS reason codes approved for use in Medicare 835, National Standard Format (NSF) and standard Medicare paper remittance advice transactions.

These reason codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment. CAS reason codes may be used at the service or claim level, as appropriate. At least one CAS reason code must be used per claim. Code 93, 'no claim level adjustments', must be used at the claim level when there have not been any adjustments. Multiple CAS reason codes may be entered for each service or claim as warranted.

Early in the history of CAS reason codes, some codes, such as 69-83 were implemented for informational rather than adjustment purposes. However, these codes and their amounts interfered with balancing of the remittance data. Approval of new codes is now limited to those that involve an adjustment from the amount billed.

There are basic criteria that the X12 Claims Adjustment and Status Task Group considers when evaluating requests for new codes:

1. Can the information be conveyed by the use or modification of an existing CAS reason code?
2. Is the information available elsewhere in the 835?
3. Will the addition of the new CAS reason code make any significant difference in the action taken by the provider who receives the message?

Requests for CAS reason code changes must satisfy these questions prior to approval.

CAS

Code

ValueMessage

1	Deductible Amount
2	Coinsurance Amount
3	Co-Payment Amount
4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's sex.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's sex.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Claim/service denied because the submitted authorization number is missing or invalid, or does not apply to the billed services.
16	Claim/service lacks information which is needed for adjudication.
17	Claim/service denied because requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury and thus the liability of the Worker's Compensation carrier.
20	Claim denied because this injury is covered by the liability carrier.
21	Claim denied because this injury is the liability of the no-fault carrier.
22	Claim denied because this care may be covered by another payer per coordination of benefits.
23	Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits.
24	Payment for charges denied. Charges are covered under a capitation agreement.
25	Charges denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time service was provided.
29	The time limit for filing has expired.
30	Benefits are not available for these services until the patient has met the required waiting or residency period.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
36 *	Balance does not exceed co-payment amount.
37 *	Balance does not exceed deductible.

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38	Services are not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/precertification was requested.
40	Charges do not meet qualifications for emergency/urgent care.
41 *	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
CAS	
Code	
<u>Value</u>	<u>Message</u>
44	Prompt-pay discount.
45	Charges exceed your contracted/legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis (es) are not covered.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition.
52	The referring/prescribing provider is not eligible to refer/prescribe/order the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by the payer.
57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges reduced as penalty for failure to obtain second surgical opinion.
62	Penalty taken for absence of or exceeded pre-certification authorization.
63 *	Correction to a prior claim.
64 *	Denial reversed per Medical Review.
65 *	Procedure code was incorrect. This payment reflects the correct code.
66	Blood deductible.
67 *	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68 *	DRG weight. (Handled in CLP12)
69	Day outlier amount.

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70 Cost outlier amount.  
 71 Primary payer amount.  
 72 \* Coinsurance day. (Handled in QTY, QTY01=CD)  
 73 ^ Administrative days.  
 74 Indirect medical education adjustment.  
 75 Direct medical education adjustment.  
 76 Disproportionate share adjustment.  
 77 \* Covered days. (Handled in QTY, QTY01=CA)  
 78 Non-covered days/Room charge adjustment.  
 79 ^ Cost report days. (Handled in MIA15)  
 80 ^ Outlier days. (Handled in QTY, QTY01=OU)  
 81 \* Discharges.  
 82 \* PIP days.  
 83 \* Total visits.  
 84 ^ Capital adjustment. (Handled in MIA)  
 85 Interest amount.

CAS

Code

<u>Value</u>	<u>Message</u>
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86	Statutory adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92 *	Claim paid in full.
93	No claim level adjustments.
94	Processed in excess of charges.
95	Benefits reduced. Plan procedures not followed.
96	Non-covered charges.
97	Payment is included in the allowance for the basic service/procedure.
98 *	The hospital must file the Medicare claim for this inpatient non-physician service.
99 *	Medicare Secondary Payer adjustment amount.
100	Payment made to patient/insured/responsible party.
101	Predetermination, anticipated payment upon completion of services.
102	Major medical adjustment.
103	Provider promotional discount (i.e. Senior citizen discount)
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Claim/service denied/reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.

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112 Claim/service denied/reduced as not furnished directly to the patient and/or not documented.

113 Claim denied because service/procedure was provided outside of the United States or as result of war.

114 Procedure/product not approved by the Food and Drug Administration.

115 Claim/service denied/reduced as procedure postponed or canceled.

116 Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care.

118 Charges reduced for ESRD network support.

119 Benefit maximum for this time period has been reached.

120 Patient is covered by a managed care plan.

121 Indemnification adjustment.

122 Psychiatric reduction.

123 Payor refund amount due to overpayment.

124 Payor refund amount--not our patient.

125 Claim/service denied/reduced due to a submission/billing error(s).

126 Deductible--major medical.

127 Coinsurance--major medical.

128 Newborn's services are covered in the mother's allowance.

129 Claim denied--prior processing information appears incorrect.

130 Paper claim submission fee.

131 Claim specific negotiated discount.

CAS

Code

<u>Value</u>	<u>Message</u>
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132	Prearranged demonstration project adjustment.
133	This service is suspended pending further review.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3 ^	Medicare Secondary Payer liability met.
A4	Medicare claim PPS day capital outlier amount.
A5	Medicare claim PPS cost capital outlier amount.
A6	Prior hospitalization or 30-day transfer requirement not met.
A7	Presumptive payment adjustment.
A8	Claim denied. Ungroupable DRG.
B1	Non-covered visits.
B2 *	Covered visits.
B3 *	Covered charges.
B4	Late filing penalty.
B5	Claim/service denied/reduced because coverage guidelines were not met or were exceeded.
B6	This service/procedure is denied/reduced 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.
B7	This provider was not certified for this procedure/service on this date

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- of service.
- B8 Claim/service not covered/reduced because alternative services were available, and should have been utilized.
- B9 Services are not covered because the patient is enrolled in a hospice.
- 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.
- B11 The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- B12 Services not documented in patient's medical records.
- B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B14 Claim/service denied because only one visit or consultation per physician per day is covered.
- B15 Claim/service denied/reduced because this procedure/service is not paid separately.
- B16 Claim/service denied/reduced because "New Patient" qualifications were not met.
- B17 Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
- B18 Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
- B19 ` Claim/service denied/reduced because of the finding of a review organization.
- B20 Charges denied/reduced because procedure/service was partially or fully furnished by another provider.
- B21 \* The charges were reduced because the service/care was partially furnished by another physician.
- B22 This claim/service is denied/reduced based on the diagnosis.
- B23 Claim/service denied because this provider has failed an aspect of a proficiency testing program.

CAS

Code

Value            Message

- D1 ` Claim/service denied. Level of subluxation is missing or inadequate.
- D2 ` Claim lacks the name, strength or dosage of the drug furnished.
- D3 ` Claim,/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
- D4 ` Claim/service does not indicate the period of time for which this will be needed.
- D5 ` Claim/service denied. Claim lacks individual lab codes included in the test.
- D6 ` Claim/service denied. Claim did not include patient's medical record for the service.
- D7 ` Claim/service denied. Claim lacks date of patient's most recent physician visit.
- D8 ` Claim/service denied. Claim lacks indicator that "X-ray is available for review."
- 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.
- D10 ` Claim/service denied. Completed physician financial relationship form not on file.
  - D11 ` Claim lacks completed pacemaker registration form.
  - D12 ` Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
  - D13 ` Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
  - D14 ` Claim lacks indication that the plan of treatment is on file.
  - D15 ` Claim lacks indication that service was supervised or evaluated by a physician.

**For demonstration program use only:**

- D97 Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
- D98 Part B coinsurance. (Part B Center of Excellence Demonstration)
- D99 Adjustment to the pre-demonstration rate.

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**STANDARD PROVIDER LEVEL ADJUSTMENT (PLB) REASON CODES**

The PLB segment carries provider level financial adjustment data which is not related to the adjustment data for the claims addressed in a specific 835 transaction. As with the CAS financial adjustment segments, positive numbers in monetary amount elements have a negative arithmetic value in the balancing routines while negative numbers in monetary amount elements have a positive arithmetic value in the balancing routines.

PLB

Code

ValueMessage

AA	Receivable today
AW	Accelerated payment withholding
AP	Accelerated Payment Amount
BD	Bad debt pass-through amount
BF	Balance forward; a negative balance to be carried forward and applied in a subsequent billing cycle.
BN	Bonus; used to report a Medicare Transitional Outpatient PPS payment.
CA	Manual claims adjustment; approved claim payments calculated outside normal processing.
CO	Carryover; a negative balance amount which has been carried forward from a previous billing cycle and applied in the current billing cycle.
CP	Capital pass-through amount
CR	Nurse anesthetist pass-through amount (CRNA)
CW	Claim withholding
CX	Total cancel claim amount
DM	Direct medical education pass-through amount
DS	Disproportionate share amount
FS	Final settlement amount (Cost Report)
GM	Graduate medical education pass-through amount
IM	Indirect medical education pass-through amount
IN	Interest paid
IP	Interest assessed on late-filed cost reports and/or delinquent refunds
IR	Interim rate lump sum adjustment
J1	Nonreimbursable
KA	Organ acquisition pass-through amount
LR	Late cost report penalty amount
NP	Non-physician pass-through amount
OA	Part A offset for affiliated provider
OB	Part B offset for affiliated provider
OR	Overpayment recovery; overpayment amount not fully satisfied in prior cycles
OS	Outside recovery; money withheld for external organizations, i.e., IRS
PA	Adjustment for claims paid after PIP effective date. (This amount must be multiplied by negative one [-1].)
PL	PIP lump sum adjustment

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PO Other pass-through amount  
PP PIP payment  
PR Provider refund adjustment. (To be used for credit balance reconciliation.)  
PS Pass-through lump sum adjustment  
PW Penalty withholding  
RA Check received from the provider for credit balancing for Part A amounts due.

**(Modified 4/1/00 as update to version 3051.4A.01)**

PLB Code

Value            Message

RB Check received from the provider for credit balancing for Part B amounts due.  
RE Return on equity  
RF Refunds  
RI Reissued check amount  
RS Penalty release amount  
SW Settlement withhold amount  
TR Retroactive adjustment (Cost Report)  
TS Tentative settlement (Cost Report)

(Modified 4/1/00 as update to version 3051.4A.01)

**MEDICARE LINE LEVEL REMARK CODES (6/98)**

Remark codes must be used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by HCFA. As with the CAS reason codes, Medicare contractors are also prohibited from use of local remark codes.

Remark codes and messages must be used whenever they apply. Although contractors may use their discretion to determine when certain remark codes apply, they do not have discretion as to whether to use an applicable remark code in a remittance notice. A limitation of liability message (M25-M27) must be used where applicable. Up to 19 Medicare line level remark codes may be entered as warranted in an X12 835 RA. There is a limit of 5 line level remark code entries in a NSF RA and on a standard paper remittance notice.

**Line Level Remark Codes**

<u>Code</u>	<u>Message</u>
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased or after the total of issued rental payments equals the purchase price.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only

received an injection.

M15 Separately billed services/tests have been bundled under a single procedure code as they are considered components of that same procedure. Separate payment is not allowed.

M16 Please see the letter or bulletin of (date) for further information.  
[Note: Contractor must enter the date of the letter/bulletin.]

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<u>Code</u>	
<u>Value</u>	<u>Message</u>
M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.
M19	Oxygen certification/recertification (HCFA-484) is incomplete.
M20	HCPCS needed.
M21	Claim for services/items provided in a home must indicate the place of residence.
M22	Claim lacks the number of miles traveled.
M23	Invoice needed for the cost of the material or contrast agent.
M24	Claim must indicate the number of doses per vial.
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- o If you did not know, and could not have reasonably been expected to know, that we would not pay for this service:  
or
- o If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional

information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

Code

Value

Message

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(1) of the Social Security Act and 42CFR411.408 . The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

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M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Claim lacks the operative report.
M30	Claim lacks the pathology report.
M31	Claim lacks the radiology report.
M32	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33	Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid. (Substitute NPI for UPIN when the NPI is effective.)
M34	Claim lacks the CLIA certification number.
M35	Claim lacks pre-operative photos or visual field results.
Code	
<u>Value</u>	<u>Message</u>
M36	This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37	Service not covered when the beneficiary is under age 35.
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.
M43	Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.
M44	Incomplete/invalid condition code.
M45	Incomplete/invalid occurrence codes and dates.
M46	Incomplete/invalid occurrence span code and dates.
M47	Incomplete/invalid internal or document control number.
M48	Medicare payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49	Incomplete/invalid value code(s) and/or amount(s).
M50	Incomplete/invalid revenue code(s).
M51	Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes. (Add to message for carriers only: Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.)
M52	Incomplete/invalid "from" date(s) of service.

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- M53 Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
  - M54 Did not complete or enter the correct total charges for services rendered.
  - M55 Medicare does not pay for self-administered anti-emetic drugs that are not administered with a Medicare-covered oral anti-cancer drug.
  - M56 Incomplete/invalid payer identification.
  - M57 Incomplete/invalid provider number. (Substitute NPI for provider number when the NPI is effective.)
  - M58 Please resubmit the claim with the missing/correct information so that it may be processed.
  - M59 Incomplete/invalid "to" date(s) of service.
  - M60 Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.
  - M61 We cannot pay for this as the approval period for the FDA clinical trial has expired.
  - M62 Incomplete/invalid treatment authorization code.
  - M63 Medicare does not pay for more than one of these on the same day.
  - M64 Incomplete/invalid other diagnosis code.
  - M65 Only one technical component or interpretation can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each technical component code or interpretation code.

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<u>Code</u>	<u>Message</u>
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Incomplete/invalid other procedure code(s) and/or date(s).
M68	Incomplete/invalid attending or referring physician identification.
M69	Paid at the regular rate as you did not submit documentation to justify modifier 22.
M70	NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.
M72	Did not enter full 8-digit date (MM/DD/CCYY).
M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.
M74	This service does not qualify for a HPSA bonus payment.
M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76	Incomplete/invalid patient's diagnosis(es) and condition(s).
M77	Incomplete/invalid place of service(s).
M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79	Did not complete or enter the appropriate charge for each listed service.
M80	We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.
M81	Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82	Service is not covered when beneficiary is under age 50.
M83	Service is not covered unless the beneficiary is classified as at high risk.
M84	Old and new HCPCS cannot be billed for the same date of service.
M85	Subjected to review of physician evaluation and management services.
M86	Service denied because payment already made for similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home Health Medical Review Initiative.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped

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- rental period will not begin.
- M95 Services subjected to Home Health Initiative medical review/cost report audit.
- M96 The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.

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<u>Code</u>	
<u>Value</u>	<u>Message</u>
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Incomplete/invalid/missing Universal Product Number.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.
M103	Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service.
M105	Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108	Must report the PIN of the physician who interpreted the diagnostic test. (Substitute NPI for PIN when effective.)
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring physician.
M110	Missing/invalid provider number for the provider for whom you purchased interpretation services.
M111	We do not pay for chiropractic manipulative treatment when the beneficiary refuses to have an x-ray taken.
M112	and following. Reserved for future use.

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MEDICARE CLAIM LEVEL REMARKS CODES

A maximum of 5 claim level Medicare Inpatient Adjudication (MIA) or 5 claim level Medicare Outpatient Adjudication (MOA) remarks codes may be used per claim. See the Medicare 835 Implementation Guides. Individual Medicare MIA/MOA remarks codes listed in this document must also be used in the NSF and the standard paper remittance notice. See NSF and standard paper remittance notice specifications for use of Medicare MIA/MOA remarks codes in the NSF and on the standard paper RAs.

Medicare MIA/MOA remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. As with the adjustment reason codes and Medicare line level remarks codes, Medicare contractors are prohibited from using local MIA/MOA codes.

An appropriate appeal, limitation of liability or other message must be used whenever applicable. Although contractors have discretion to determine when certain remarks codes and messages apply, they do not have discretion as to whether to use applicable codes and messages.

Code

Value

Message

MA01 (Initial Part B determination, carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

(NOTE: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)

MA02 (Initial Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO.

(An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

## Code

ValueMessage

MA03 (Hearing)--If you do not agree with the Medicare approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 Incorrect admission date, patient status or type of bill entry on claim. (NOTE: See MA30, MA40 and MA43 also.)

MA06 Incorrect beginning and/or ending date(s) on claim.

MA07 The claim information has also been forwarded to Medicaid for review.

MA08 You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

MA09 Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10 The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13 You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

- MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
- MA17 We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

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<u>Code</u>	
<u>Value</u>	<u>Message</u>
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.
MA22	Payment of less than \$1.00 suppressed.
MA23	Demand bill approved as result of medical review.
MA24	Christian Science Sanatorium/SNF bill in the same benefit period.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Our records indicate that you were previously informed of this rule.
MA27	Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.
MA28	Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA29	Incomplete/invalid provider name, city, state, and zip code.
MA30	Incomplete/invalid type of bill.
MA31	Incomplete/invalid beginning and ending dates of the period billed.
MA32	Incomplete/invalid number of covered days during the billing period.
MA33	Incomplete/invalid number of noncovered days during the billing period.
MA34	Incomplete/invalid number of coinsurance days during the billing period.
MA35	Incomplete/invalid number of lifetime reserve days.
MA36	Incomplete/invalid patient's name.
MA37	Incomplete/invalid patient's address. (Note: When used, a Medicare contractor must verify that an address, with city, State, and zip code, and a phone number are present.)
MA38	Incomplete/invalid patient's birthdate.
MA39	Incomplete/invalid patient's sex.
MA40	Incomplete/invalid admission date.
MA41	Incomplete/invalid type of admission.
MA42	Incomplete/invalid source of admission.
MA43	Incomplete/invalid patient status.
MA44	No appeal rights on this claim. Every adjudicative decision based on Medicare law.
MA45	As previously advised, a portion or all of your payment is being held in a special account.
MA46	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As

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a result, we cannot pay for this claim. The patient is responsible for payment.

MA48 Incomplete/invalid name and/or address of responsible party or primary payer .

MA49 Incomplete/invalid six-digit Medicare provider number of home health agency or hospice for physician(s) performing care plan oversight services.

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<u>Code</u>	<u>Message</u>
MA50	Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52	Did not enter full 8-digit date (MM/DD/CCYY).
MA53	Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54	Physician certification or election consent for hospice care not received timely.
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58	Incomplete release of information indicator.
MA59	The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60	Incomplete/invalid patient's relationship to insured.
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62	Telephone review decision.
MA63	Incomplete/invalid principal diagnosis code.
MA64	Our records indicate that Medicare should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Incomplete/invalid admitting diagnosis.
MA66	Incomplete/invalid principal procedure code and/or date.
MA67	Correction to a prior claim.
MA68	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.
MA69	Incomplete/invalid remarks.
MA70	Incomplete provider representative signature.
MA71	Incomplete/invalid provider representative signature date.
MA72	The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice.
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected

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managed care.

- MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
- MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
- MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.

Code

Value

Message

- MA77 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary's payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.
- MA78 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.
- MA79 Billed in excess of interim rate.
- MA80 Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
- MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.
- MA82 Did not complete or enter the correct physician/supplier's Medicare number/NPI and/or billing name, address, city, state, zip code, and phone number.
- MA83 Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
- MA84 Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
- MA85 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the primary payer's plan or program name. (Substitute "PAYERID" for "their plan or program name" when effective.)
- MA86 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.
- MA87 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.
- MA88 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.
- MA89 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.
- MA90 Our records indicate that there is insurance primary to Medicare;

however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91 This determination is the result of the appeal you filed.

MA92 Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.

(NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93 Change to non-PIP claim.

MA94 Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95 A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

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<u>Code</u>	<u>Message</u>
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
MA97	Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.
MA98	Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
A99	Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.
MA100	Did not complete or enter accurately the date of current illness, injury or pregnancy.
MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.
MA102	Did not complete or enter accurately the referring/ordering/supervising physician's/practitioner's name and/or UPIN. (Substitute "NPI" for "UPIN" when effective.)
MA103	Hemophilia Add On.
MA104	Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)
MA105	Missing/invalid provider number for this place of service. Place of service code shown as 21, 22 or 23 (hospital). (Substitute "NPI" for provider number when effective.)
MA106-109	Reserved for future use.
MA110	Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Our records indicate that the performing physician/supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)
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.
MA114	Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute "NPI" for "PIN" when effective.)
MA115	Our records indicate that you billed one or more services in a Health

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Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute "NPI" for "PIN" when effective.)

- MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
- MA117 This claim has been assessed a \$1.00 user fee.
- MA118-MA119 Reserved for future use

Code

Value            Message

- MA120 Did not complete or accurately enter the CLIA number.
- MA121 Did not complete or enter accurately the date the X-Ray was performed.
- MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.
- MA123 Your center was not selected to participate in this study; therefore, we cannot pay for these services.
- MA124 Processed for IME only.
- MA125-127 Reserved for future use
- MA128 Did not complete or enter accurately the six digit FDA approved, identification number.
- MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Please contact \_\_\_\_\_ to correct or obtain CLIA certification. (Claim processor must provide the name and phone number of the State Agency to be contacted.)
- MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- MA131 and higher Reserved for future use.

**VALUE CODES PROVIDING MSP INFORMATION**

The value codes listed below provide MSP primary payer information when placed in MIA/MOA Remark Code elements. The MSP primary payer amount used to offset the Medicare payment is placed in a CAS segment with a CAS adjustment reason code 71.

Value

Code            Message

- 12 Working Aged Beneficiary/Spouse With an EGHP
- 13 ESRD Beneficiary in a Medicare Coordination Period With an EGHP
- 14 No-Fault, Including Auto/Other Insurance
- 15 Worker's Compensation (WC)
- 16 PHS, Other Federal Agency

- 41 Black Lung
- 42 Veterans Affairs
- 43 Disabled Beneficiary Under Age 65 With LGHP
- 47 Any Liability Insurance