



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
 Sequenced by HIPAA Remark Code
 Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		0197	MISSING/INVALID NCPDP MAND	95 (02/01/16)	Plan procedures not followed.
		0395	INITIAL PRESCRIPTION LIMITED TO A 34 DAY SUPPLY	154 (02/01/16)	Payer deems the information submitted does not support this day's supply.
		0396	REFILL RX LIMITED TO 34 DAYS / 100 UNITS	154 (01/29/16)	Payer deems the information submitted does not support this day's supply.
		0402	NOT COVERED BY GA - BILL ADDP	109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
		0405	POSSIBLE THERAPEUTIC CLASS DUPLICATION	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
		0407	THERAPEUTIC DUPE; CLAIM THRESHOLD EXCEEDED	222 (01/29/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0416	PRESCRIPTION VOLUME EXCEEDS THRESHOLD - PA REQUIRED	176 (01/29/16)	Prescription is not current.
		0431	OTHER PAYOR ID REQUIRED WITH TPL PAYMENT	95 (01/03/16)	Plan procedures not followed.
		0433	"POSSIBLE UNDERUTILIZATION; MEP UNIT TO CONTACT MD"	95 (01/03/16)	Plan procedures not followed.
		0438	PAYOR ID QUALIFIER DOES NOT EQUAL 99 PBM LIST	109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
		0439	INVALID OTHER PAYOR ID CODE NOT ON PBM LIST	109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
		0440	LTC PHARMACY INELIGIBLE FOR UD RECYCLING.	B7 (01/03/16)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		0441	NUMBER OF UNITS RESTOCKED EXCEEDS ORIGINAL UNITS PAID	222 (01/03/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0442	ORIGINAL CLAIM INELIGIBLE FOR UNIT DOSE RESTOCKING/RECYCLING	222 (01/03/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0445	TPL NOT ON RESOURCE FILE BUT TPL AMT ON CLAIM	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		0446	DRUG NOT COVERED BY CF PROGRAM	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		0447	DAILY DOSE EXCEEDS REC.LIMITS FOR DRUG FOUND IN COMBO PROD.	175 (01/01/16)	Prescription is incomplete.
		0449	"INAPPROPRIATE NARCOTIC USE"	177 (01/03/16)	Patient has not met the required eligibility requirements.
		0459	CLAIM PYMT ADJUSTED DUE TO OTHER INSURANCE.	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		0463	UNIT RECAPTURE ADJUSTMENTS	153 (01/03/16)	Payer deems the information submitted does not support this dosage.
		0466	COMPOUND CLAIM WITH ONLY ONE INGREDIENT	175 (01/03/16)	Prescription is incomplete.
		0478	NO LONGER ACCEPT PAPER COMPOUND CLAIMS	95 (01/03/16)	Plan procedures not followed.
		0512	DRUG NOT PAYABLE - NO ADDP REBATE AGREEMENT	95 (02/01/16)	Plan procedures not followed.
		0549	DRUG NOT PAYABLE - NO REBATE AGREEMENT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		0556	COMPOUND DRUG NOT COVERED	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0557	COMPOUND DRUG NOT COVERED FOR PAAD RECIPIENT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0562	COMP DRUG WITH INGREDIENT NOT COVERED BY REBATE AGREEMENT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0570	DRUG NOT PAYABLE - NO STATE REBATE AGREEMENT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0756	DRUG SUPPLIED EARLY - REVIEW REQUIRED	175 (01/29/16)	Prescription is incomplete.
		0785	MAINFRAME CLAIM NOT PRESENT ON POS HISTORY	107 (01/01/16)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0828	PHARMACY EXACT DUPLICATE BILL - DIFFERENT PROVIDER	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
		0829	EARLY REFILL -SAME PROVIDER - DENIED AFTER REVIEW	222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		0830	EARLY REFILL - SAME PROVIDER WITH NO ATTACHMENT 08	222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0831	EARLY REFILL - DIFFERENT PROVIDER - DENIED AFTER REVIEW	222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0832	EARLY REFILL - DIFFERENT PROVIDER WITH NO ATTACHMENT 08	222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0870	POSSIBLE WARFARIN CONFLICT	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.
		0877	SEVERE DD INTERACTION; PA REQUIRED FOR DIFFERENT PRESCRIBERS	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.
		0879	MEDICARE / PAAD ADJUSTMENT	95 (01/29/16)	Plan procedures not followed.
		0880	CUMULATIVE RETRO REVIEW - FOR INTERNAL USE.	95 (01/29/16)	Plan procedures not followed.
		0885	NON PAR. PHARM PROV SERV W/PA 6/01/01 PAAD/ SENIOR GOLD	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		0887	POS/MATCHING HISTORY NOT FOUND	261 (01/29/16)	The procedure or service is inconsistent with the patient's history.
		0890	EARLY REFILL-SAME PROVIDER - DENIED AFTER REVIEW	175 (01/29/16)	Prescription is incomplete.
		0891	EARLY REFILL-SAME PROVIDER WITH NO ATTACHMENT 08	175 (01/29/16)	Prescription is incomplete.



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		0893	INSURANCE COVERAGE KNOWN, BILL TPL	P21 (01/29/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.
		0894	OVERRIDE FOR EDIT 893	B11 (01/29/16)	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
		0897	EARLY REFILL-DIFFERENT PROVIDER-DENIED AFTER REVIEW	175 (01/29/16)	Prescription is incomplete.
		0898	EARLY REFILL-DIFFERENT PROVIDER WITH NO ATTACHMENT 08	175 (01/29/16)	Prescription is incomplete.
		0916	SEVERE DRUG/DRUG INTERACTION DUR	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.
		0960	CLAIM UPDATED WITH PATIENT PAYMENT	275 (06/13/13)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
		0961	SYSTEM UPDATE TO PATIENT INCOME	275 (06/13/16)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
		1239	MOTHER OF NEWBORN HAS SERVICE IN-PLAN	128 (01/01/16)	Newborn's services are covered in the mother's Allowance.
		2000	SERVICE ADMINISTRATIVELY DENIED	39 (01/01/16)	Services denied at the time authorization/pre-certification was requested.
		2001	COMPOUND CONTAINS DUPLICATE INGREDIENTS	175 (01/01/16)	Prescription is incomplete.
		2002	LTC COMPOUND MUST CONTAIN ACTUAL NDC	175 (01/01/16)	Prescription is incomplete.



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		2003	COMPOUND DRUG-INCORRECT INGREDIENT QUANTITY/COST	175 (01/01/16)	Prescription is incomplete.
		2004	CLAIM PENDING RE-ENROLLMENT	177 (01/01/16)	Patient has not met the required eligibility requirements.
		2005	MEDICARE PART D DEDUCTIBLE AMT MUST BE BETWEEN 0 AND 250.00	95 (01/01/16)	Plan procedures not followed.
		2006	PART D COINS/COPAY AMT IS A NEGATIVE NUMBER	95 (01/01/16)	Plan procedures not followed.
		2007	PA INDICATOR ON THE DRUG FILE IS = 'A' OR 'Y'	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2011	PART D CLAIM PAID BY A DIFFERENT PDP THAN ON OUR FILE	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2017	PART D COVERAGE KNOWN BILL FOR PART D PLAN	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2019	PART D COINS/COPAY + DEDUCTIBLE CANNOT BOTH BE ZERO	95 (01/01/16)	Plan procedures not followed.
		2021	PART D WRAPAROUND WITH PA	95 (01/01/16)	Plan procedures not followed.
		2022	PART D CLAIM FOR BENE WITH MULTI ELIG - RESUBMIT WITH ALT ID#	95 (01/01/16)	Plan procedures not followed.
		2023	BENEFICIARY INELIGIBLE FOR PART D ON DOS	32 (01/01/16)	Our records indicate the patient is not an eligible dependent.
		2024	PART D DRUG EMERGENCY SUPPLY - ONE TIME ONLY	175 (01/01/16)	Prescription is incomplete.
		2026	PART D EMERGENCY SUPPLY OF ANTIBIOTICS - FULL PRESCRIPTION	175 (01/01/16)	Prescription is incomplete.
		2028	CLAIM PAYMENT THRESHOLD EXCEEDS \$25000 / 125000	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.



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		2029	PART D PAPER CLAIM NOT ALLOWED FOR PART D COB CLAIMS	95 (01/01/16)	Plan procedures not followed.
		2030	PART D CO-PAYMENT/CO-INSURANCE EXCEEDS ANNUAL AMT	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
		2031	PART D CO-PAYMENT/CO-INSURANCE EXCEEDS ANNUAL AMT	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
		2033	PAAD/SG/ADDP CLAIMS ONLY - PAID CLAIMS FOR NON PART D DRUG	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2034	MEDICARE PART D - NOT COVERED AS WRAPAROUND BENEFIT	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2036	RECIPIENT NOT ELIGIBLE FOR MAILORDER SERVICES	32 (01/01/16)	Our records indicate the patient is not an eligible dependent.
		2038	FIRST FILL OF THIS DRUG (BY NDC/GCN/STC) REQUIRES PRIOR AUTH	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2039	EXEMPT LTC RECIPIENTS FROM MEDICARE PART CO-PAYMENT	B11 (01/01/16)	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
		2040	MEDICARE PART D CO-PAYMENT EXCEEDS MAX ALLOWED.	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
		2041	TITLE XIX RECIPIENT-INVALID PART D DEDUCTIBLE AMOUNT	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2042	COPAY EXCEEDS CHARGE FOR 3 MONTH SUPPLY FOR RECIP LIS LEVEL	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
		2043	RECIPIENT ELIGIBLE FOR MEDICARE PART D	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.



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		2044	PART D-EMERGENCY SUPPLY MAY BE FILLED ONLY ONCE IN 90 DAYS	204 (02/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2046	PRESCRIPTION NOT ALLOWED DUE TO CHANGE IN THERAPY	153 (01/01/16)	Payer deems the information submitted does not support this dosage.
		2047	PA REQUIRED: DRUG / PRESCRIBER RESTRICTION	175 (01/01/16)	Prescription is incomplete.
		2048	PHARMACY NOT APPROVED STATE PROVIDER	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2050	LICENSE # ONLY ACCEPTED FOR NPI EXCLUDED ENTITIES.	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2051	FIELD 466-EZ MAY NOT CONTAIN 05 QUALIFIER - USE 01 FOR NPI	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2052	PART D CLAIM EMERGENCY SUPPLY - NO PDP REJECT CODE	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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		2053	PART D REJECT CODE CONFLICTS WITH PDP PAYMENT AMOUNT	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2054	CLAIM IS INCORRECTLY BILLED - NO MEDICARE ON FILE.	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2056	THE LENGTH OF THE SERVICE/BILLING NPI IS INVALID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2057	SERVICE/BILLING PROVIDER NPI FAIL CHECK DIGIT 201-B1	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2058	SERVICING/BILLING PROVIDER NPI IS REQUIRED OF 05/23/08	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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		2059	THE FIRST DIGIT OF THE SERVICING/BILLING NPI IS INVALID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2060	THE MEDICAID ID IS NOT FOUND FOR SERVICING/BILLING NPI	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2061	FOUND MULTIPLE MEDICAID IDS FOR THE SERVICING/BILLING NPI	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2062	THE LENGTH OF THE PRESCRIBER NPI IS INVALID - 411-DB	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2063	CHECK DIGIT VALIDATION FAIL FOR THE PRESCRIBER NPI	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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		2064	PRESCRIBER NPI IS REQUIRED AS OF 05/23/08	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2065	THE FIRST DIGIT OF PRESCRIBER NPI IS INVALID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2069	METRIC QUANTITY MUST REFLECT WHOLE PACKAGE	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2070	EXCEEDS MAXIMUM METRIC QUANTITY FOR PACKAGE SIZE/ FULL PKGS	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2071	PAAD RECIPIENTW/ MEDICAID ELIGIBILITY	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2072	DUPLICATE STATE LICENSE # FOUND ON PROVIDER FILE	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2073	REQUESTOR IS NOT AUTHORIZED TO VOID/ADJUST THIS CLAIM	150 (01/29/16)	Payer deems the information submitted does not support this level of service.
		2074	CLAIM HAS BEEN PREVIOUSLY VOIDED BY STATE - CANNOT RESUBMIT	P14 (01/29/16)	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.
		2076	SENIOR GOLD RECIPIENT W/MEDICAID ELIGIBILITY	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2083	DAYS SUPPLY > 34 FOR NURSING HOME EARLY REFILL	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2084	PRESCRIPTION FILLED BY MAILORDER PHARMACY	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2085	MAC OVERRIDE NOT ALLOWED - DISPENSE AS WRITTEN IND INCORRECT	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2086	SUBMISSION OF 6666666 FOR NJ PRESCRIBER IS INVALID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2089	DIABETIC SUPPLIES NOT COVERED - BILL MCARE PT B OR OTH TPL	109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
		2090	PRESCRIBER LIC#/QUALIFIER N/A WHEN NPI EXISTS	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2097	PHARMACY BILLED FOR TPL COPAY/COINSURANCE	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2098	INVALID COMPOUND - CONTAINS ONE INGREDIENT PLUS WATER	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2099	INCORRECT UNIT OF MEASURE REPORTED FOR DRUG	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2100	FDB DAILY DOSAGE QUANTITY STANDARD EXCEEDED	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2102	DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2107	WRONG OTHER PAYER ID (340-7C) CORRECT CLIENT INFO & RESUBMIT	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2108	CARDHOLDER ID INVALID	31 (01/01/16)	Patient cannot be identified as our insured.
		2109	DRUG NOT PAYABLE DUE TO CHANGE IN COVERAGE RULES	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2110	PATIENT PAID AMOUNT UNKNOWN	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
		2111	NOT COVERED FOR RELIEF OF COUGH AND COLD SYMPTOMS	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2112	CONFLICTING GENDER CODE - CONFIRM GENDER AND BENE ID NUMBER	10 (01/01/16)	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2113	CONFLICTING DATE OF BIRTH - CONFIRM DOB AND BENE ID NUMBER	14 (01/01/16)	The date of birth follows the date of service.
		2115	AWP WITH PRE-SETTLEMENT FORMULA LESS THAN AWP ON FILE	95 (01/29/16)	Plan procedures not followed.
		2117	INCORRECT BILLING PROVIDER NUMBER FOR INSTITUTIONAL SERVICES	185 (01/01/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2118	THERAPEUTIC DUPLICATE FOUND USING NATIONAL STANDARD	18 (01/01/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
		2119	NON-COVERED NDC PER CMS/FDA RESTRICTION	114 (01/01/16)	Procedure/product not approved by the Food and Drug Administration.
		2120	LAST CHARACTER OF SIGNED FIELD IS NUMERIC & MUST BE SIGNED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2121	OTC NOT ON MEDICAID PART D WRAPAROUND	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2122	PARTD DEDUCTIBLE INVALID FOR TITLE XIX BENEFICIARY	95 (01/29/16)	Plan procedures not followed.
		2124	PA NUMBER FIELD CONTAINING AUDIT DATA REQUIRED FOR HMS AUDIT	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
		2125	DRUG NOT COVERED FOR ADDP LIMITED COVERAGE PROGRAM	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2127	HMS AUDIT B1 REPLACEMENT CLAIM, ORIG CLM NOT AUDITED BY HMS	95 (01/29/16)	Plan procedures not followed.
		2128	6-DIGIT ICN ON HMS AUDIT CLAIM DOES NOT MATCH NJMMIS CLAIM	140 (01/01/16)	Patient/Insured health identification number and name do not match.
		2129	HMS AUDIT ADJUSTMENT REASON 42/47 ADDED TO POS HISTORY CLAIM	95 (01/29/16)	Plan procedures not followed.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2130	HMS TPL CLAIM W/NO COB AMOUNTS	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2131	CMS UNMATCHED NDC ACCORDING TO FDB EDITORIAL (BLENDED) INFO	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2132	ANTIPSYCHOTIC DRUG-56 DAYS AT MAX DOSE REQ BEFORE SWITCHING	153 (01/29/16)	Payer deems the information submitted does not support this dosage.
		2133	ANTIPSYCHOTIC DRUG-OVERLAPPING USAGE OF 2+ DRUGS > 42 DAYS	153 (01/29/16)	Payer deems the information submitted does not support this dosage.
		2134	PSYCHOTROPIC DRUGS-FIVE OR MORE USED CONCURRENTLY	59 (01/29/16)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2136	COB SEGMENT AND NO TPL PAID INFORMATION ON INPUT CLAIM	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2137	PART D COPAY NOT COVERED AS OF FY2012	212 (01/01/16)	Administrative surcharges are not covered
		2139	TPL PAYMENT AND REJECT CODE FOR OTHER PRIVATE PAYER	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2140	OTHER COVERAGE CODE=03 & CLAIM HAS NO SUPPORTING REJECT CODE	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2141	TPL PAYMENT AND OTHER COVERAGE CODE NOT EQUAL 02	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2143	MINIMUM 180 DAYS REQUIRED FOR VACCINATION CLAIM	175 (01/29/16)	Prescription is incomplete.
		2144	ADDP PARTD-SUBMIT 10-DIGIT ADDP ID NUMBER NOT HBID NUMBER	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2145	PART B COVERAGE KNOWN - BILL PART B/PART D/TPL	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2146	COVERED BY ADPP HEALTH INSURANCE CONTINUATION (HIC) PROGRAM	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
		2173	INCORRECT PRESCRIBER DEA#/NPI# SUBMITTED		
		2174	PRESCRIPTION NOT VALID FOR DOS	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2176	INELIGIBLE PRESCRIBER BASED ON CMS LIST	173 (01/29/16)	Service/equipment was not prescribed by a physician.
		2177	INELIGIBLE PHARMACY	170 (01/29/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2178	INCORRECT PATIENT INFORMATION SUBMITTED	31 (01/29/16)	Patient cannot be identified as our insured.
		2179	INAPPROPRIATE PRESCRIBER	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2180	EXCESSIVE QUANTITY BILLED FOR DAYS SUPPLY SUBMITTED	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2181	QTY EXCEEDS DS LIMITS & INCORRECT PACKAGE SIZE BILLED/DISP	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2182	RX INCOMPLETE; MISSING DATE WRITTEN	175 (01/29/16)	Prescription is incomplete.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2184	RX INCOMPLTE; MISSING MORE THAN ONE REQUIRED COMPONENT	175 (01/29/16)	Prescription is incomplete.
		2185	RX INCOMPLETE, MISSING PRESCR INFO/PRESCR SIG/AUTH AGENT/DEA	175 (01/29/16)	Prescription is incomplete.
		2186	RX IS INCOMPLETE-PAT NAME IS AMBIG/INCOMPLETE	175 (01/29/16)	Prescription is incomplete.
		2187	RX INCOMPLETE; MISSING DIRECTIONS, DRUG NAME, STRENGTH/QTY	175 (01/29/16)	Prescription is incomplete.
		2188	RX/DOCUMENTATION IS ILLEGIBLE	175 (01/29/16)	Prescription is incomplete.
		2189	HMS-INITIATED FAIR HEARING OVERRIDE	B12 (01/29/16)	Services not documented in patient's medical records.
		2190	RETURNED TO STOCK PRESCRIPTION	173 (01/29/16)	Service/equipment was not prescribed by a physician.
		2192	UNNECESSARY QUANTITY REDUCTION	B10 (01/29/16)	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.
		2193	MISSING/INCOMPLETE SIGNATURE/DELIVERY LOG/CERTIF STATEMENT	175 (01/29/16)	Prescription is incomplete.
		2194	RX DISPENSED AFTER DATE OF DEATH	174 (01/29/16)	Service was not prescribed prior to delivery.
		2195	QUANTITY BILLED IS GREATER THAN THE QUANTITY DELIVERED	234 (01/29/16)	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.)
		2196	RX NOT TAMPER RESISTANT	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2197	UNDOCUMENTED AUTHORIZATION OF REFILL	224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
		2198	STOLEN PRESCRIPTION PAD	224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
		2199	ACQUISITION NON-MATCH (NDC)	224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
		2200	MISSING ACQUISITION RECORD	224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
		2201	INCORRECT/INVALID DATE RANGE ON INVOICE FOR NDC ON CLAIM	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2202	DE DEA# ON CONTROLLED RX (CII THRU CV) MISSING OR INVALID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2203	EQ MAXIMUM DAILY QTY EXCEED	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2204	RH STRENGTH ON PRESCRIPTION MISSING	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2205	RU DIRECTIONS FOR USE MISSING	174 (01/29/16)	Service was not prescribed prior to delivery.
		2206	TPL CLAIM FOR PATIENT WITH PART D - SHOULD BE PART D CLAIM	174 (01/29/16)	Service was not prescribed prior to delivery.
		2207	RX INCOMPLETE/MISSING/AMBIG/INCOMPLETE PRESCRIBER SIGNATURE	175 (01/29/16)	Prescription is incomplete.
		2208	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS QUANTITY	175 (01/29/16)	Prescription is incomplete.
		2209	SIGNATURE OR DELIVERY LOG IS INCOMPLETE	175 (01/29/16)	Prescription is incomplete.
		2210	NO SIGNATURE ON CLAIM LOG	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
		2211	INSUFFICIENT INVOICE QUANTITY	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2212	INVOICE IS ILLEGIBLE	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
		2213	INSUFFICIENT QTY-INVOICE DOC DOES NOT SUPPORT QTY BILLED	16 (02/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2214	CLAIMS WAS PREVIOUSLY RESERVED BY THE PHARMACY	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2215	PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2216	CLAIM RESERVED AND MEDICATION WAS RETURNED TO STOCK	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2220	INVALID FACILITY NAME FOR FACILITY ID	58 (01/29/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2221	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2222	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMT QUALIFIER	50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2223	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2224	INVALID OTHER PAYER AMOUNT PAID QUALIFIER FOR D.0 CLAIM	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2225	INVALID OTHER COVERAGE CODE FOR NCPDP D.0 CLAIM	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2226	INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD	95 (01/29/16)	Plan procedures not followed.
		2227	DIAGNOSIS CODE QUALIFIER VALUES ARE NOT EQUAL	11 (01/29/16)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2228	PAYER-PAT DATA FOR HEALTH PLAN FUNDED ASSISTANCE(129-UD) > 0	169 (01/29/16)	Alternate benefit has been provided.
		2229	MISSING QUALIFIER FOR OTHER PAYER AMOUNT PAID	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2230	INVALID PATIENT RESIDENCE CODE. MUST BE 00-15	31 (01/29/16)	Patient cannot be identified as our insured.
		2231	BENEFIT STAGE AMOUNT IS NOT NUMERIC	4 (01/29/16)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2232	BENEFIT STAGE AMOUNT SUBMITTED FOR DEDUCTIBLE STAGE	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2233	BENEFIT STAGE AMOUNT SUBMITTED FOR INITIAL STAGE	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2234	BENEFIT STAGE AMOUNT SUBMITTED FOR DONUT HOLE STAGE	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2235	BENEFIT STAGE AMOUNT SUBMITTED FOR CATASTROPHIC STAGE	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
		2236	PARTD PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED	109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
		2237	OTHER PAYER-PATIENT RESP AMT COUNT NOT EQUAL # REPETITIONS	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2238	OTHER PAYER-PATIENT RESP AMT DOES NOT HAVE A CORRESP QUAL	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2239	BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS.	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2240	OTHER PAYER ID FIELD MISSING OR INVALID	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2241	INVALID BENEFIT STAGE AMOUNT, NO PARTD PAYER SUBMITTED	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2242	BENEFIT STAGE 50, NOT PART D-PART B DRUG PAID UNDER PART C	B10 (01/29/16)	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.
		2243	BENEFIT STAGE 60 - NOT PART D - SUPPLEMENTAL BENEFIT	B10 (01/29/16)	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.
		2244	BNFT STG 70-NOT PARTD CLM-PD BY NEGOTIATED PRICE-PARTD DRUG	B10 (01/29/16)	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.
		2245	BNFT STG 80-NOT PARTD CLM-PD BY NGTIATED PRC-NOT PARTD DRUG	B10 (01/29/16)	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.
		2246	BNFT STG 60/62/80/90 NOT ON FORMULARY EXCEPTION	B10 (01/29/16)	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.
		2247	FACILITY ID IS MISSING OR INVALID	58 (01/29/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		2248	FACILITY ID NOT ON FILE FOR ACTIVE LTC PROVIDER	185 (01/29/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2249	GERIATRIC PRECAUTION FOUND-DRUG IS ON BEERS/HEDIS/STOPP LIST	56 (01/29/16)	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2250	TPL PAYER ID REQUIRED WHEN BILLING FOR TPL COPAY/COINSURANCE	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2266	INELIGIBLE PRESCRIBER, 15-DAY GRACE PERIOD BEGINS FOR RECIP	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2267	GRACE PERIOD LIMITED TO 30 DAYS SUPPLY FOR NORMAL SOLID DOSE	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2268	INELIGIBLE PRESCRIBER, PRESCRIPTION IN 15-DAY GRACE PERIOD	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2269	INELIGIBLE PRESCRIBER-OUTSIDE GRACE PERIOD, NO FILLS ALLOWED	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2270	PROVIDER ONLY AUTHORIZED TO PRESCRIBE-NOT A BILLING PROV	170 (01/29/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2271	PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2272	PRESCRIBER NPI MAPS TO GROUP NUMBER-PRESCRIBER MUST BE INDIV	184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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		2274	BNFT STG 61-NOT PARTD CLM-PD BY COADMIN PLAN BNFT-PARTD DRUG	B10 (01/29/16)	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.
		2275	BNFT STG 62-NOT PARTD CLM-PD BY COADMIN PLAN-NOT PARTD DRUG	B10 (01/29/16)	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.
		2276	BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED	169 (01/29/16)	Alternate benefit has been provided.
		2277	VOID RECEIVED AFTER HOURS-HELD UNTIL POS SYSTEM AVAILABLE	166 (01/29/16)	These services were submitted after this payers responsibility for processing claims under this plan ended.
		2278	CARDHOLDER ID ON PARTD VOID IS INVALID	31 (01/29/16)	Patient cannot be identified as our insured.
		2284	DRUG SUBJECT TO MEDICAL REVIEW	197 (01/29/16)	Precertification/authorization/notification/pre-treatment absent.
		2285	COMPOUND INGREDIENT DRUG COST IS NON-NUMERIC OR NEGATIVE	175 (01/29/16)	Prescription is incomplete.
		2295	FACILITY PROVIDER IS NOT ACTIVE ON THE DATE OF SERVICE	B7 (01/29/16)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2302	344-HF QUANTITY INTENDED TO BE DISPENSED IS NOT NUMERIC	175 (01/29/16)	Prescription is incomplete.
		2303	345-HG DAYS SUPPLY INTENDED TO BE DISPENSED IS NOT NUMERIC	175 (01/29/16)	Prescription is incomplete.
		2304	600-28 UNIT OF MEASURE NOT VALID VALUE (EA/GM/ML)	175 (01/29/16)	Prescription is incomplete.
		2306	442-E7 QUANTITY DISPENSED NOT NUMERIC OR IS NEGATIVE	175 (01/29/16)	Prescription is incomplete.
		2307	414-DE PRESCRIPTION DATE IS NOT NUMERIC	175 (01/29/16)	Prescription is incomplete.
		2308	335-2C PREGNANCY INDICATOR IS NOT 1, 2 OR BLANK	175 (01/29/16)	Prescription is incomplete.



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		2309	409-D9 INGREDIENT COST IS NOT NUMERIC OR GREATER THAN ZERO	175 (01/29/16)	Prescription is incomplete.
		2310	412-DC DISPENSING FEE SUBMITTED IS NOT NUMERIC	175 (01/29/16)	Prescription is incomplete.
		2311	466-EZ PRESCRIBE QUALIFIER ID IS NOT VALID VALUE 01,05 OR 08	175 (01/29/16)	Prescription is incomplete.
		2312	411-DB PRESCRIBER ID IS BLANK OR NOT SUBMITTED	175 (01/29/16)	Prescription is incomplete.
		2313	406-D6 COMPOUND CODE IS NOT 1 OR 2	175 (01/29/16)	Prescription is incomplete.
		2314	407-D7 INVALID COMBINATION OF NDC, CMPND NDC OR CMPND CODE	175 (01/29/16)	Prescription is incomplete.
		2315	488-RE COMPOUND PRODUCT ID QUALIFIER IS NOT 03	175 (01/29/16)	Prescription is incomplete.
		2319	202-B2 SERVICE PROVIDER ID QUALIFIER NOT 01	175 (01/29/16)	Prescription is incomplete.
		2320	455-EM PRESCRIPTION/SERVICE REFERENCE NUM QUALIFIER IS NOT 1	175 (01/29/16)	Prescription is incomplete.
		2321	436-E1 PROD/SERV ID QUAL NOT 03 FOR SINGLE OR 00 FOR CMPND	175 (01/29/16)	Prescription is incomplete.
		2322	492-WE DIAGNOSIS CODE QUALIFIER IS NOT 01, 02, 00 OR BLANK	175 (01/29/16)	Prescription is incomplete.
		2326	301-C1 GROUP ID IS NOT BLANK	175 (01/29/16)	Prescription is incomplete.
M7 (01/01/14)	No rental payments after the item is purchased, returned or after the total of issued rental payments equals the purchase price.	1608	INITIAL DETERMINATION OF PURCHASE	92 (06/01/10)	Claim Paid in full.
M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0483	LAB TEST INCLUDED IN ESRD COMPOSITE RATE	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0486	PHARMACY {DRUGS} INCLUDED IN ESRD COMPOSITE RATE	234 (11/01/15)	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.)
M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0487	MEDICAL SUPPLIES INCLUDED IN THE ESRD COMPOSITE RATE	234 (11/01/15)	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.)
M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0547	UNIT DOSE PAYABLE FOR NURSING HOME RECIPIENT ONLY	B15 (10/16/03)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0703	EPISIOTOMY INCLUDED IN DELIVERY CHARGE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0713	LAB TEST CONFLICT/LAB PANEL PROCEDURE PREVIOUSLY PAID	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0714	LAB TEST CONFLICT, INDIVIDUAL TEST(S) PREVIOUSLY PAID	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0741	PROCEDURE DENIED - COMPONENT PREVIOUSLY PD CLAIM	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0746	MASS ADJ: BILLED CHARGES MODIFIED TO PERMIT ADJ-SEE REC-569	234 (11/01/15)	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.)



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M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0950	RE-PROCESSED PREVIOUSLY DENIED CLAIM	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1605	FQHC PAID HIGHEST DELIVERY, OB/GYN OR ENCOUNTER CLAIM	234 (11/01/15)	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.)
M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1818	CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1892	CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M20 (10/16/03)	Missing/incomplete/invalid HCPCS.	0165	EMC - INVALID HCPCS PROCEDURE PREFIX	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M20 (06/04/07)	Missing/incomplete/invalid HCPCS.	1215	PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE	16 (06/04/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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M25 (02/01/16)	The information furnished does not substantiate the need for this level of 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 level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	0843	ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC	151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
M25 (11/01/15)	The information furnished does not substantiate the need for this level of 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 level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	1013	OP XOVER PR RE-PRICING	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
M28 (10/16/03)	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	0939	RECIPIENT IS MEDICARE PART A ELIGIBLE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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M44 (01/01/14)	Missing/incomplete/invalid condition code.	0062	INVALID CONDITION CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M44 (10/16/03)	Missing/incomplete/invalid condition code.	0417	GENERIC SUBSTITUTION REQUIRED OR INAPPROPRIATE DAW	226 (01/01/14)	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.)
M44 (10/16/03)	Missing/incomplete/invalid condition code.	0457	LTC FACILITY ID MISSING ON POS REBILL UNIT DOSE RESTOCK	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M44 (10/16/03)	Missing/incomplete/invalid condition code.	0462	RENAL REVENUE CODE PRESENT - RENAL CONDITION CODE REQUIRED	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M44 (04/05/11)	Missing/incomplete/invalid condition code.	2135	EDI AGREEMENT REQUIRED FOR NCPDP D.O CLAIM	204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan
M45 (11/01/15)	Missing/incomplete/invalid occurrence code(s).	0060	INV/MISS OCCURENCE CODE - SUPPLY VALID CODE OR REMOVE DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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M45 (10/16/03)	Missing/incomplete/invalid occurrence code(s).	0461	ESRD CLAIM-OCCURRENCE CODE 35 REQUIRED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (01/01/14)	Missing/incomplete/invalid occurrence span code(s).	1200	ALC OCC SPAN DAY DOES NOT MATCH THE NUMBER OF REVENUE UNITS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (11/01/15)	Missing/incomplete/invalid occurrence span code(s).	1284	INVALID/MISSING UB04 OCCURRENCE SPAN CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (12/09/13)	Missing/incomplete/invalid occurrence span code(s).	1400	NO OCCURRENCE SPAN CODE 74 OR 77	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	0019	INVALID INTERNAL CONTROL NUMBER (ICN)	252 (11/01/15)	An attachment/other documentation 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).



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	0080	ICN DATE IS > 2 YRS FROM SERVICE DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	0847	INCORRECT ICN ON FD-999	252 (11/01/15)	An attachment/other documentation 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).
M47 (11/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	0995	NO MATCHING HISTORY CLAIM FOR CREDIT RECORD	252 (11/01/15)	An attachment/other documentation 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).
M47 (11/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	0997	IMAGINERY CLAIM - REVIEW REQUIRED	252 (11/01/15)	An attachment/other documentation 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).
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0050	BLOOD NOT REPLACED AMOUNT MUST BE NUMERIC	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0052	TOTAL BLOOD PINTS FURNISHED INCORRECT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0065	PINTS OF BLOOD FURNISHED MUST BE NUMERIC	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0075	PINTS OF BLOOD REPLACED NOT NUMERIC	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0132	INV/MISS NURSING FACILITY (LTCF) INDICATOR	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0176	MCARE DEDUCTIBLE AMOUNT MUST BE NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0177	MCARE COINSURANCE AMOUNT MUST BE NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M49 (10/16/03)	Missing/incomplete/invalid value code(s) or amount(s).	0181	TOTAL TPL AMOUNT MUST BE NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0182	OVERRIDE CODE NOT NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0184	INVALID/MISSING ADJUSTMENT REASON	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0186	MEDICARE ALLOWED NOT NUMERIC OR NOT > ZERO	16 (01/01/13)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0187	DEDUCTIBLE, BLOOD DEDUCTIBLE, AND/OR COINSURANCE AMT MISSING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0188	CASH DEDUCTIBLE AMOUNT EXCEEDS THE YEARLY MAXIMUM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0193	MEDICAID CHARGES PLUS TPL AMOUNT < 50% BILLED CHARGES	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0194	MISSING MEDICAID CHARGES	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0580	CLAIM ERROR REASONS > 10	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0989	INVALID APPROPRIATION CODE ASSIGNMENT	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).	0994	NO MATCHING PA MASTER FOR AJ CREDIT	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (05/23/07)	Missing/incomplete/invalid value code(s) or amount(s).	1235	NPI NOT ON FILE FOR SERVICE/RENDERING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (06/08/09)	Missing/incomplete/invalid value code(s) or amount(s).	1321	CLAIM UOM INVALID OR NOT = NDC UOM - SEE WWW.NJMMIS.COM	16 (06/08/09)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (01/01/14)	Missing/incomplete/invalid value code(s) or amount(s).	1810	CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL	55 (04/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).	0031	CONDITION CODE 85/C3 PRESENT, REQUIRES REVENUE CODE 912	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).	0034	MISSING LABORATORY SERVICE REVENUE CODE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).	0079	INPATIENT CLAIM-REQUIRES AT LEAST ONE ACCOMMODATION REV CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (01/01/14)	Missing/incomplete/invalid revenue code(s).	0257	PROC/NDC/REV/ICD NOT CVRD BY MA, MA-RELATED, PAAD/SR GOLD	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).	0503	REVENUE CODE NOT ON FILE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).	1310	MISSING/INVALID DENTAL CLINIC REV CODE.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (01/01/15)	Missing/incomplete/invalid revenue code(s).	1341	INVALID REVENUE CODE FOR OUTPATIENT OBSERVATION SERVICES	150 (01/01/15)	Payer deems the information submitted does not support this level of service.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).	1647	REVENUE CODE INVALID FOR LONG TERM PSYCH CLAIMS	185 (07/16/12)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).	0134	USE PROPER PROCEDURE CD. SEE NEWSLTR VOL 2 #61 DATED 11/92	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).	0259	HCPCS PROCEDURE CODE NOT ON FILE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).	0265	SERVICE NOT PAYABLE TO ASC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).	0272	USE PROPER PRO CODE -SEE NEWSLETTER VOL.2 #61 DATED 11/92	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).	0663	USE PROPER PROCEDURE CODE-SEE NEWSLETTER P669 DATED 08/91	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).	0668	USE ASSIGNED PROC CODE/NDC CODE TO MATCH DESCRIPTION GIVEN	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).	0723	LAB PANEL PROCEDURE CODE NOT ON FILE	B15 (01/01/14)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).	0770	PROCEDURE CODE/NDC NOT INCLUDED IN PRIOR AUTHORIZATION	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).	1311	MISSING/INVALID DENTAL PROCEDURE CODE.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (10/03/16)	Missing/incomplete/invalid procedure code(s).	1449	ICD10 SURG PROC CD MAINTENANCE. REPROCESS ON APPROVAL.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (10/31/16)	Missing/incomplete/invalid procedure code(s).	1450	ICD10 DIAG CD MAINTENANCE. REPROCESS ON APPROVAL.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).	1634	NON-EMERGENCY TRANSPORTATION PROCEDURE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1808	CLAIM CHECK: INVALID PROCEDURE CODE	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1811	CLAIM CHECK: PROCEDURE CODE IS OBSOLETE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1822	CLAIM CHECK: MISSING PROCEDURE CODE	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).	1830	CLAIM CHECK: NUMBER OF PROCEDURES IS GREATER THAN 100	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (01/01/13)	Missing/incomplete/invalid procedure code(s).	1877	CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1885	CLAIM CHECK: CCI INCIDENTAL PROCEDURE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1886	CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1887	CLAIM CHECK: INCIDENTAL PROCEDURE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1889	CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1896	CLAIM CHECK: MEDICAL VISIT PROCEDURE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).	1897	CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	0016	INV/MISS SERVICE FROM DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	0071	INVALID STATEMENT COVERS FROM DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (06/18/07)	Missing/incomplete/invalid 'from' date(s) of service.	1820	CLAIM CHECK: DATE OF SERVICE IS A FUTURE DATE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) of service.	1851	CLAIM CHECK: INVALID CLAIM DATE OF SERVICE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) of service.	1852	CLAIM CHECK: INVALID DATE OF SERVICE	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0035	HOSPICE CLAIM - NUMBER OF UNITS NOT EQUAL TO NUMBER OF DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0036	INVALID ACUTE DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0037	INVALID SNF DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0038	INVALID ICF DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0039	INVALID RESIDENTIAL DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0046	TOTAL DAYS NOT EQUAL TO DATES OF SERVICE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0053	INV/MISS ACCOMMODATION DAYS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0056	INV/MISS REVENUE UNITS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0085	INV/MISS DAYS/UNITS/VISITS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0086	NUMBER OF UNITS EXCEEDS MONTHS/DAYS OF SERVICE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0178	BLOOD DEDUCTIBLE (PINTS) MUST BE NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0258	AMBULATORY SURGICAL CENTER-DAYS/DATES INCONSISTENT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (02/02/04)	Missing/incomplete/invalid days or units of service.	0374	REPORTED SERVICE UNITS MUST BE GREATER THAN 1 & LESS THAN 6	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0472	FQHC ENCOUNT BILLED UNITS GT PAID HCPCS UNITS ON HIST	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (09/01/20)	Missing/incomplete/invalid days or units of service.	0585	SERVICE UNITS INCONSISTENT WITH PRODUCT PACKAGING	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	0660	NUMBER OF ACCOMMODATION DAYS NOT EQUAL TO TOTAL BILLED DAYS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	0771	DAY SUPPLY INCORRECTLY REPORTED AS ONE DAY.	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	1001	REVENUE UNITS (OCCURS 45 TIMES) ARE GREATER THAN 999	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	1002	DAYS ACUTE ARE GREATER THAN 999	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	1003	DAYS SNF ARE GREATER THAN 999	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	1004	DAYS ICF ARE GREATER THAN 999	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	1005	DAYS RESIDENTIAL ARE > 999	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/22/22)	Missing/incomplete/invalid days or units of service.	1712	DIABETES SERVICES CLM HAS NO REQ'D PREV CLMS ON HISTORY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/22/22)	Missing/incomplete/invalid days or units of service.	1713	DIABETES SERVICES EXCEED LIMIT	119 (11/22/22)	Benefit maximum for this time period or occurrence has been reached.
M53 (09/01/20)	Missing/incomplete/invalid days or units of service.	2158	DS AND QTY CHANGED TO BE CONSISTENT WITH DOCTOR'S DIRECTIONS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (09/01/20)	Missing/incomplete/invalid days or units of service.	2160	WRONG DAYS SUPPLY; CHNGED TO BE CONSISTENT W/ DR'S DIRCTNS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (10/16/03)	Missing/incomplete/invalid total charges.	0152	INV/MISS TOTAL CHARGE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M54 (10/16/03)	Missing/incomplete/invalid total charges.	0153	INCORRECT TOTAL CHARGES	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (10/16/03)	Missing/incomplete/invalid total charges.	0473	TOTAL CALCULATED CHARGE NOT EQUAL TO TOTAL BILLED CHARGE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (10/16/03)	Missing/incomplete/invalid total charges.	0474	NET CALCULATED CHARGES NOT EQUAL TO NET BILLED CHARGE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (01/01/14)	Missing/incomplete/invalid total charges.	0588	OTHER PAYER CHGS ARE MISSING VALUE CODE 24 AND AMOUNT REQ	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (06/18/07)	Missing/incomplete/invalid total charges.	1853	CLAIM CHECK: INVALID CHARGE AMOUNT	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M56 (10/16/03)	Missing/incomplete/invalid payer identifier.	0172	INVALID PAYOR ID	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M56 (01/01/14)	Missing/incomplete/invalid payer identifier.	0983	RESOURCE FILE INDICATES INSURANCE OTHER THAN PAYOR ID CODED	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M56 (10/16/03)	Missing/incomplete/invalid payer identifier.	0986	INVALID PAYOR ID	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M56 (11/01/15)	Missing/incomplete/invalid payer identifier.	1324	EFFECT 1/1/2012 PYMT WILL BE DEFERRED PENDING ACH ENROLLMENT	16 (04/02/10)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0245	ATTACHMENT REQUIRED OR INCORRECT ATTACHMENT FOR PROCEDURES	252 (11/01/15)	An attachment/other documentation 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).
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0320	MED NEEDY SPENDDOWN - INVALID/MISSING ATTACHMENT	252 (11/01/15)	An attachment/other documentation 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).



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0408	PRIOR AUTHORIZATION NUMBER INVALID	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0412	GSHP QA/QU PRIOR AUTHORIZATION REQUIRED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0422	MANAGED CARE RECIPIENT-PRIOR AUTHORIZATION REQUIRED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0423	PRIOR AUTHORIZATION REQUIRED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (10/16/03)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	0797	DUPLICATE ADJUSTMENT RECORDS ENTERED	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1352	DME AUDIT - NO DOCUMENTATION - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1353	DME AUDIT - INCORRECT RECIP IDENT - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1354	DME AUDIT - NO PROOF OF PURCHASE - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1355	DME AUDIT - NO PROOF OF DELIVERY - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1356	DME AUDIT - NO PRESCRIBER ORDER - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1357	DME AUDIT - DIFFERENT PROC/PRODUCT - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1358	DME AUDIT - DIFFERENT QTY BILLED/AUTH - (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1359	DME AUDIT - DIFFERENT PROC BILLED/AUTH - CALL (800-310-0865)	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1360	DME AUDIT - NO PRICE LIST - CALL (800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1361	DME AUDIT- INVALID DATE OF SERVICE - CALL(800) 310-0865	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1424	NO ASSOCIATION FOUND FOR DDD-SP/CCW SVC LOCATION NPI	185 (11/07/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	1425	INVALID DIAGNOSIS FOR SERVICE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2010	WRONG PCN (104-A4) - VALUE MUST = SUPPNJ, ADDP, OR PAAD	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2096	PATIENT PAID AMOUNT UNKNOWN - 433-DX	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2150	HMS AUDITORS NOT ALLOWED IN PHARMACY	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2152	CLAIM DOES NOT BELONG TO PHARMACY	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2155	CLAIM WAS PREVIOUSLY RESERVED BY THE PHARMACY	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2161	ERRONEOUS CLAIM	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2163	MISSING INGREDIENTS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2164	DRUG BILLED IS DIFFERENT THAN PRESCRIBED/DISPENSED	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2165	INCORRECT QUANTITY BILLED FOR SINGLE PACKAGE ITEM	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2167	RESPONSE RECEIVED AFTER ALLOTTED TIMEFRAME	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2168	MISSING FAX HEADER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2171	PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2172	INCORRECT OR INVALID DAW/DNS SUBMITTED	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2191	COPY OF RX WAS NOT PROVIDED	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	2325	OPIOID DRUG NOT FOUND ON MME FACTOR TABLE	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M59 (11/01/15)	Missing/incomplete/invalid 'to' date(s) of service.	0015	STATEMENT THRU DATE < STATEMENT FROM DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	0017	INV/MISS SERVICE THRU DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	0020	SERVICE THRU DATE > DATE RECEIVED - VERIFY SERVICE THRU DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	0072	INVALID STATEMENT COVERS THRU DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (01/29/16)	Missing/incomplete/invalid 'to' date(s) of service.	0981	BENEFICIARY/DATES OF SERVICE DO NOT MATCH EOB/LETTER	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M60 (11/01/15)	Missing Certificate of Medical Necessity.	0336	ABORTION REQUIRES REVIEW	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M60 (11/01/15)	Missing Certificate of Medical Necessity.	0337	STERILIZATION FORM REQUIRES REVIEW	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
M62 (11/01/15)	Missing/incomplete/invalid treatment authorization code.	0055	A 1 IS NOT PRESENT IN THE PA IND FIELD AND PA # IS PRESENT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M62 (11/01/15)	Missing/incomplete/invalid treatment authorization code.	0283	PROVIDER LIMITED TO NON-DYFS BENEFICIARIES	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.	0409	PROSTHETIC AND/OR ORTHOTIC CHARGES REQUIRES PA	210 (01/01/14)	Payment adjusted because pre-certification/authorization not received in a timely fashion
M62 (09/01/20)	Missing/incomplete/invalid treatment authorization code.	0577	PA REQUIRED FOR WFNJ/GA DRUG COVERAGE	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0704	OUTPATIENT ACUTE-ADULT PARTIAL HOSPITALIZATION - PA REQUIRED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0772	PA/PROVIDER NOT AUTHORIZED	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0774	PRIOR AUTHORIZATION NOT ON FILE	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0775	PA RECORD ON FILE IS NOT ACTIVE	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.	0777	GSHP PA ALREADY PROCESSED	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0779	MEDICAID PRIOR AUTHORIZATION NUMBER INVALID	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0780	GSHP PRIOR AUTHORIZATION NOT ON FILE	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0781	GSHP PRIOR AUTHORIZATION RECORD NOT ACTIVE	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0783	GSHP PROCEDURE NOT INCLUDED IN PRIOR AUTHORIZATION	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.	0867	PCA SERVICES > 25 HRS. & VALID PA NUMBER NOT ON CLAIM.	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (01/02/14)	Missing/incomplete/invalid treatment authorization code.	0868	PCA UNITS OF SERVICE EXCEEDS WEEKLY ALLOWABLE ON THE PA.	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.	0926	AUTHORIZATION PERIOD FOR ORTHO SVCS EXCEEDED/ PA REQUIRED	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.
M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.	0937	PRIOR AUTHORIZED UNITS USED FOR CLAIM PAYMENT	62 (10/16/03)	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
M62 (09/01/20)	Missing/incomplete/invalid treatment authorization code.	2148	PA NUMBER INPUT REQUIRES SPECIAL FORMAT FOR HMS TPL CLAIMS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M64 (10/16/03)	Missing/incomplete/invalid other diagnosis.	0290	INVALID SECONDARY DIAGNOSIS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M64 (01/01/14)	Missing/incomplete/invalid other diagnosis.	0295	INVALID THIRD OR SUBSEQUENT DIAGNOSIS.	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.	1289	UB04 ADMIT DIAGNOSIS NOT ON FILE	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.	1290	UB04 PAT RSN VISIT REQD - UNSCHEDULED VISIT	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.	1291	INVALID UB04 PATIENT REASON FOR VISIT	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.	1292	UB04 PATIENT REASON FOR VISIT NOT ON FILE	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.	1293	INVALID UB04 EXTERNAL INJURY CODE	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.	1294	UB04 EXTERNAL INJURY CODE NOT ON FILE	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
M64 (10/01/14)	Missing/incomplete/invalid other diagnosis.	1416	ICD VERSION MISMATCH	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M67 (10/16/03)	Missing/incomplete/invalid other procedure code(s).	0708	GLOBAL OB CARE/SERVICE CONFLICT	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).	1602	OP PSYCH SERVICE IN CONFLICT WITH Y99XX CLAIM	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).	1616	FQHC HCPCS WITH NO ENCOUNTER FOUND	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).	1653	PAYMT BASED ON AFFORDABLE CARE ACT ENHANCED RATES CY 13 & 14	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M69 (10/16/03)	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.	0633	AMBULANCE/INVALID COACH < 16 MILES	117 (10/16/03)	Transportation is only covered to the closest facility that can provide the necessary care.
M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.	0166	INV/MISS DIAGNOSIS CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.	0167	MISSING PRIMARY DIAGNOSIS CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.	0296	DIAGNOSIS CODE NOT ON FILE	146 (11/01/15)	Diagnosis was invalid for the date(s) of service reported.
M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.	0361	INSUFFICIENT MEDICAL DOCUMENTATION FOR HYSTERECTOMY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.	0362	CLAIM IS POSSIBLE STERILIZATION	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.	0363	CLAIM IS POSSIBLE ABORTION	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1801	CLAIM CHECK: CLM DIAG INVALID BASED ON ICD-9 EXPIRATION DT	146 (06/18/07)	Diagnosis was invalid for the date(s) of service reported.
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1802	CLAIM CHECK: CLM DIAGNOSIS INVALID ICD-10	146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1843	CLAIM CHECK: INVALID DIAGNOSIS CODE	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1847	CLAIM CHECK: INVALID DIAGNOSIS CODE	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1879	CLAIM CHECK: DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DT	146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.
M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.	1880	CLAIM CHECK: DIAGNOSIS INVALID ICD-10	146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.
M77 (01/01/14)	Missing/incomplete/invalid/inappropriate place of service.	0141	INV/MISS PLACE OF SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M77 (11/01/15)	Missing/incomplete/invalid/inappropriate place of service.	0208	PROVIDER APPROVED FOR EMC ONLY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M77 (11/01/15)	Missing/incomplete/invalid/inappropriate place of service.	1314	HOSPICE PROCEDURE/PLACE OF SERVICE RESTRICTION	5 (11/01/15)	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	0109	ALLOWABLE AMOUNT IS LESS THAN CO-PAY AMOUNT	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M79 (11/01/15)	Missing/incomplete/invalid charge.	0151	INV/MISS CLAIM LINE CHARGE(S)	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	0175	BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (02/01/16)	Missing/incomplete/invalid charge.	0607	LOW VARIANCE ERROR	16 (02/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	0646	MISSING NEW YORK REGIONAL BAD DEBT MULTIPLIER	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	1010	INVALID LTC PATIENT/OTHER PAYMENT AMOUNT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M79 (11/01/15)	Missing/incomplete/invalid charge.	1362	LTC XOVER MISSING MCARE PAID &/OR MCARE COV DAYS &/OR COINS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (10/20/14)	Missing/incomplete/invalid charge.	1618	MEDICARE PART A REQUIRED FOR MN HOSPICE SERVICES	95 (10/20/14)	Plan procedures not followed.
M79 (12/12/07)	Missing/incomplete/invalid charge.	1854	CLAIM CHECK: INVALID NUMERIC FIELD	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (12/12/07)	Missing/incomplete/invalid charge.	1857	CLAIM CHECK: NUMERIC FIELD NOT POPULATED	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M80 (10/16/03)	Not covered when performed during the same session/date as a previously processed service for the patient.	0757	DRUG SUPPLIED EARLY BY DIFFERENT PROVIDERS	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.	0758	SURGERY/ANESTHESIA CONFLICT - ANESTHESIA DENIED	194 (01/01/14)	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.	1615	CUTBACK-OBSERVATION OFFICE VISIT ALREADY PAID	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M81 (10/01/14)	You are required to code to the highest level of specificity.	1428	UNSPECIFIED DIAGNOSIS CODE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M85 (10/16/03)	Subjected to review of physician evaluation and management services.	0883	ORTHODONTIC CUTBACK/FINAL PAYMENT	23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0475	HISTORY RECORD ALREADY ADJUSTED OR VOIDED	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0625	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE	23 (10/16/03)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0670	NO PAYMENT DUE-MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWABLE	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	0700	CONFLICTING SAME DAY LAB SERVICE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	0702	SERVICE CONFLICTS WITH SIMILAR SAME DAY PROCEDURE	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	0729	CLAIM PAYMENT REDUCED FOR PREVIOUSLY PAID VISIT	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.	0742	PREVIOUS EXTRACTED TOOTH	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0749	ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE	B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.	0755	EARLY REFILL	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0826	DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0914	ROUTINE PROCE CARRIED OUT IN NICU ARE INCL IN GLOBAL FEE	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (11/01/15)	Service denied because payment already made for same/similar procedure within set time frame.	0915	MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0931	OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0935	GENERAL INPATIENT CARE & INPATIENT CLAIM BILLED SAME DAY	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	0976	MEDICAID PAYMENT REDUCED BY OTHER INSURANCE	B10 (10/16/03)	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.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1614	OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1630	MCARE LTC CLAIM WITH OVERLAPPING DOS	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1656	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ	B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1657	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA	B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1658	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NY	B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1815	CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	1895	CLAIM CHECK: DUPLICATE PROCEDURE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (09/27/11)	Service denied because payment already made for same/similar procedure within set time frame.	2142	GENERIC DRUG HAS NO PRICE - SUL/FUL/WAC/NADAC MISSING	18 (09/27/11)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
M86 (04/01/17)	Service denied because payment already made for same/similar procedure within set time frame.	2296	CLAIM NOT ELIGIBLE FOR 340B PRICING	175 (04/01/17)	Prescription is incomplete.
M87 (10/16/03)	Claim/service(s) subjected to CFO-CAP prepayment review.	0279	DENIED AS A RESULT OF PREPAYMENT REVIEW BY DMAHS	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M90 (01/01/14)	Not covered more than once in a 12 month period.	0721	CONFLICTING TARGETED CASE MANAGEMENT SERVICE	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M90 (01/01/14)	Not covered more than once in a 12 month period.	0737	PAAD/SR GOLD RECIP REFILL > 12 MO FROM ORIGINAL PRESCRIPTION	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M90 (01/01/14)	Not covered more than once in a 12 month period.	0873	KIDCARE D MENTAL HEALTH SERVICE FOR BENEFIT YEAR EXCEEDED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M97 (10/16/03)	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	0531	LTC/HOSPICE REQUIRES PR-1 OR LTC REQUIRES PATIENT PYT AMOUNT	106 (10/16/03)	Patient payment option/election not in effect.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M97 (10/16/03)	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	0664	ITEM BILLED IS INCLUDED IN ADMINISTRATION/SUPPLY KIT	97 (10/16/03)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M104 (02/01/16)	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 fee schedule for this item or service.	1899	CLAIM CHECK: BYPASS CLAIM CHECK	109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0127	NDC CODE MISSING OR INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (01/01/14)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0252	PROC/REVENUE CODE/NDC/DIAG REQUIRES REVIEW	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0540	COMPOUND DRUG FOR GSHP BENEFICIARY	150 (10/16/03)	Payer deems the information submitted does not support this level of service.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0542	NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0544	DRUG NOT PAYABLE FEDERAL DESI	150 (10/16/03)	Payer deems the information submitted does not support this level of service.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0545	NDC NOT ON DRUG FILE	B18 (01/01/14)	This procedure code and modifier were invalid on the date of service.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0551	NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0553	COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	0559	COMPOUND DRUG-NDC CODE MISSING OR INVALID	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (06/04/07)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	1214	INVALID NDC OR NDC NOT ON FILE	16 (06/04/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (09/01/20)	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	2329	OPIOID NOT FOUND ON RGCNSTR0 TABLE	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M122 (01/01/16)	Missing/incomplete/invalid level of subluxation.	0789	FORMER ICN INVALID (FFS)	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M123 (11/01/15)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	0130	INV/MISS DAYS SUPPLY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M123 (10/16/03)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	0560	COMPOUND DRUG-QUANTITY MISSING OR INVALID	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M123 (01/01/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	1300	MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY	57 (05/02/11)	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
M123 (05/02/11)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	1301	MAXIMUM DAILY DOSAGE NOT FOUND	92 (05/02/11)	Claim Paid in full.
M123 (06/08/09)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	1317	INVALID/MISSING METRIC QUANTITY	16 (06/08/09)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M124 (11/01/15)	Missing indication of whether the patient owns the equipment that requires the part or supply.	0940	CLAIM REQUIRES REVIEW - MEDICARE PART A ATTACHMENT	250 (11/01/15)	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).
M126 (01/01/14)	Missing/incomplete/invalid individual lab codes included in the test.	0091	INV/MISS EPSDT LABORATORY INDICATOR	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M127 (11/01/15)	Missing patient medical record for this service.	0341	INSUFFICIENT MEDICAL DOCUMENTATION FOR ABORTION	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
M127 (11/01/15)	Missing patient medical record for this service.	0505	LTC CENSUS DATA MISSING FOR SERVICE MONTH AND YEAR	250 (11/01/15)	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).
M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.	0322	HMO COVERED SERVICE -REVIEW REQUIRED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M129 (10/01/20)	Missing/incomplete/invalid indicator of x-ray availability for review.	1365	HMS PERMEDION NJUR	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.	1375	HMS CREDIT BALANCE RECOVERY - ON-SITE FINANCIAL REVIEW	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M135 (11/01/15)	Missing/incomplete/invalid plan of treatment.	0598	INVALID LEVEL-OF-CARE CODE	251 (11/01/15)	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).
M139 (01/01/16)	Denied services exceed the coverage limit for the demonstration.	0610	MANUAL PRICING EXCEEDS BILLED CHARGES	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
M139 (01/01/14)	Denied services exceed the coverage limit for the demonstration.	1632	PROVIDER ADULT MDC UNIT EXCEEDS 200 UNIT PER DAY	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M143 (11/01/15)	The provider must update license information with the payer.	0696	CLAIM DENIED PROVIDER NOT REENROLLED	170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	0751	PAYMENT REDUCED - SURGERY/VISIT LIMITATION	B10 (01/01/14)	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.
M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	0905	MULTIPLE SURGERY-REDUCED BY INCIDENTAL PROCEDURE	B10 (01/01/14)	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.
M144 (11/01/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	1612	PARTIAL PATIENT PAYMENT AMOUNT APPLIED	B10 (11/01/15)	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.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	1890	CLAIM CHECK: POST OPERATIVE PROCEDURE CODE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	1891	CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA04 (11/01/15)	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.	0192	MEDICAID NOT PRIMARY PAYOR SINCE TPL AMOUNT > ZERO	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	0541	COMPOUND DRUG MANUAL REVIEW REQUIRED	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	0563	NO BASE DISPENSING FEE ON FILE FOR CLAIM SERVICE DATE	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	0564	NO VOLUME DISCOUNT ON FILE FOR CLAIM SERVICE DATE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	0634	DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG PAYMENT DATE	26 (10/16/03)	Expenses incurred prior to coverage.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	0992	SET LOCATION TO STATE REVIEW	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA07 (11/08/10)	Alert: The claim information has also been forwarded to Medicaid for review.	1333	PLEASE CONTACT THE MANAGE CARE OFFICE AT 1-800-701-0710	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
MA100 (11/01/15)	Missing/incomplete/invalid date of current illness or symptoms.	0343	INVALID/MISS STERILIZATION CONSENT DATE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (08/31/04)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	0140	LABORATORY INDICATOR MUST BE Y OR N	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	0260	DIAGNOSTIC REPORT (XRAYS,LAB,ETC.) REQUESTED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	0726	INDIVID LAB TESTS EXCEEDS PANEL ALLOWANCE -REDUCED PAYMENT.	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	0727	INDIVIDUAL LAB TESTS ALLOWANCE EXCEEDS PANEL ALLOWANCE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	0728	INDIVIDUAL LAB TEST/CBC CONFLICT	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA112 (01/01/14)	Missing/incomplete/invalid group practice information.	0180	OTHER INSURANCE INDICATOR MUST BE Y OR N	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA112 (11/01/15)	Missing/incomplete/invalid group practice information.	0205	SERVICING PROVIDER IS GROUP PROVIDER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA112 (11/01/15)	Missing/incomplete/invalid group practice information.	0209	GROUP MUST BILL FOR MEMBER OF GROUP	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA112 (11/01/15)	Missing/incomplete/invalid group practice information.	0211	SERVICING PROVIDER IS GROUP-GROUP HAS NO MEMBERS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA112 (11/01/15)	Missing/incomplete/invalid group practice information.	0225	BILLING PROVIDER IS NOT A GROUP	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA112 (01/01/16)	Missing/incomplete/invalid group practice information.	1343	ADV PRACTICE NURSE INELIGIBLE TO RECEIVE ACA ENHANCED PAYMNT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA115 (11/01/15)	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	0599	INVALID LTC COUNTY OF CHARGE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.	0297	SERVICE PROVIDER NOT ENROLLED IN CLIA	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.	0298	SERVICE PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0125	THIS PROVIDER INVALID WITH MODIFIER UE OR U6 OR WI OR WR	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0129	INVALID ATTACHMENT CODE GREATER THAN 17	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0168	MISSING MANDATORY PROCEDURE CODE MODIFIER	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0169	INVALID MODIFIER FOR PROC CODE,CLM TYPE OR SERVICE DATE	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0232	'YD' OR 'UD' MODIFIER NOT ALLOWED	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (04/01/18)	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.	0335	ABORTION CERTIFICATION FORM REQUIRED	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	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.	0368	NOT LOCK IN PHARMACY/EMERGENCY SUPPLY DISPENSED	31 (11/01/15)	Patient cannot be identified as our insured.
MA130 (11/01/15)	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.	0390	INVALID: REF PROV/ RCP CNTY/REF PROV TYP/PLC OF SVC FOR PROC	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (11/01/15)	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.	0394	MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD/SR GOLD PAYMENT	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (01/01/14)	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.	0476	NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST	129 (11/01/15)	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.)
MA130 (01/01/14)	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.	0488	DRG INTERIM BILL APPROVAL REQUIRED	129 (11/01/15)	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.)
MA130 (01/01/14)	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.	0516	EPSDT FFS INCENTIVE PAYMENT ERROR	129 (11/01/15)	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.)
MA130 (01/01/14)	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.	0517	PASARR RECORD MISSING	129 (11/01/15)	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.)
MA130 (01/01/14)	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.	0518	INVALID PASARR DATA	129 (11/01/15)	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.)



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MA130 (01/01/14)	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.	0548	DAYS SUPPLY EXCEEDS PROGRAM MAX	154 (01/01/14)	Payer deems the information submitted does not support this day's supply.
MA130 (01/01/14)	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.	0589	MODIFIER NOT ALLOWED	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0594	CLAIM NOT ELIGIBLE FOR ADD-ON DATE OF SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0603	PROVIDER NOT ON DRG RATE FILE	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
MA130 (11/01/15)	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.	0604	INVALID PRICING ACTION CODE	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	0613	DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE	26 (01/01/14)	Expenses incurred prior to coverage.



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MA130 (01/01/14)	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.	0624	NO VALID PRICE FOR DATE OF SERVICE ON USUAL & CUSTOMARY FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/16)	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.	0794	FINANCIAL CORRECTION REQUIRED	129 (01/01/16)	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.)
MA130 (11/01/15)	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.	0869	POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT	129 (11/01/15)	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.)
MA130 (11/01/15)	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.	0952	CLAIM VOIDED - RECIPIENT ID ERROR	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (01/01/14)	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.	1022	CAPITATION PAYMENT REDUCED BY MAX PATIENT PAYMENT LIABILITY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1025	CAP PAYMENT PART REDUCED BY MAX PATIENT LIABILITY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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MA130 (01/01/14)	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.	1249	MISSING PRIMARY PAYER IDENTIFICATION	129 (01/01/14)	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.)
MA130 (01/01/14)	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.	1250	MISSING SECONDARY PAYER IDENTIFICATION	129 (01/01/14)	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.)
MA130 (01/01/14)	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.	1251	MISSING TERTIARY PAYER IDENTIFICATION	129 (01/01/14)	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.)
MA130 (01/01/14)	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.	1253	SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT	129 (01/01/14)	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.)
MA130 (01/01/14)	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.	1254	INVALID PRIMARY BENEFITS EXHAUST DATE	129 (01/01/14)	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.)
MA130 (01/01/14)	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.	1342	TENT PAY PRICE USING PHY FEE INCREASE-AFFORDABLE CARE ACT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1366	HMS RECOVERY - PATIENT DECEASED ON DOS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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MA130 (01/01/14)	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.	1429	DDD-SP/CCW SVC LOCATION NPI IS INELIGIBLE FOR DOS	185 (11/07/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1430	OUTPATIENT TRANSPORTATION SERVICE HAS NO RATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1431	OUTPATIENT SERVICE NOT PAYABLE TRANS/PERS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1442	CLAIMS REPROCESS FOR DSNP MEMBERS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1451	UNKNOWN FIELD POPULATED WITH INVALID DATA	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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MA130 (01/01/14)	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.	1456	PENDING IME ROOM & BOARD CHANGES FOR SUD. REPROCESS ON APPVL	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1457	PEND ALL CLAIMS FOR PROCEDURE CODE 97127HI	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1460	CMS PROC CODE MAINTENANCE. REPROCESS ON APPROVAL	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1461	INCORRECT SUBMITTER ID FOR EVV SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1462	INCORRECT SUBMITTER ID FOR EVV SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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MA130 (11/01/15)	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.	1633	PA REQUIRED FOR PARTIAL CARE	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1635	ORIGINAL APPRP CODE NOT IN USE, FIELD UPDATED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1671	SERVICE DATE/HCPCS COMBINATION MATCH OCCURRENCE IN HISTORY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	1707	COVID VACCINE ADMINISTRATION CONFLICT	175 (03/01/21)	Prescription is incomplete.
MA130 (01/01/14)	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.	1708	MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES	175 (03/01/21)	Prescription is incomplete.
MA130 (01/01/14)	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.	1711	SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES	119 (07/01/22)	Benefit maximum for this time period or occurrence has been reached.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	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.	2138	ANONYMOUS NALOXONE BUDGET LIMIT EXCEEDED FOR THE FY	175 (12/13/22)	Prescription is incomplete.
MA130 (01/01/14)	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.	2279	CLAIM SERVICE DATE OCCURS DURING DISASTER SITUATION	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	2286	FACILITY ID NPI IS NOT NUMERIC OR CHECK DIGIT IS INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	2287	FACILITY ID NPI NOT VALID ON NPPES PROVIDER DATABASE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	2288	FACILITY NPI CANNOT BE MAPPED TO A MEDICAID ID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	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.	2289	FACILITY ID NPI MAPS TO A NON-LTC MEDICAID PROVIDER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	2327	450-EF COMPOUND DOSAGE FORM DESCRIPTION CODE IS INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	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.	2331	DATE RX WRITTEN > 30 DAYS OLD SCHED II-V	175 (09/01/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2332	DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2333	460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2334	QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2335	QTY DISPENSED > QTY PRESCRIBED	175 (09/20/20)	Prescription is incomplete.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	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.	2336	NUM OF REFILLS AUTH > O SCHED II	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2337	403-3D FILL NUMBER M/I	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2338	403-D3 NUMBER > O ON SCHED II	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2340	343-HD DISPENSING STATUS INVALID	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2342	ACCUM OF MED EXCEEDS 30 DAYS SUPPLY	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2343	NDC PRICING EXCEEDS CLASS AVG; CHANGE NDC OR PA NEEDED	204 (11/20/20)	This service/equipment/drug is not covered under the patient's current benefit plan
MA130 (01/01/14)	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.	2344	M/I INCENTIVE AMOUNT SUBMITTED FIELD (438-E3)	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2345	M/I PROFESSIONAL SERVICE CODE (445-E5)	175 (12/01/20)	Prescription is incomplete.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	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.	2350	DATE RX WRITTEN > 30 DAYS OLD SCHED II - V	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	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.	2351	OTC COVID TEST EXCEEDED- LIMIT 4 KITS PER MONTH	175 (02/28/22)	Prescription is incomplete.
MA131 (01/01/14)	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.	0962	ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA134 (11/01/15)	Missing/incomplete/invalid provider number of the facility where the patient resides.	0010	INVALID SERVICING PROVIDER MEDICAID ID NUMBER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.	0312	CORRECT RECIPIENT NUMBER AND RESUBMIT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA27 (12/01/14)	Missing/incomplete/invalid entitlement number or name shown on the claim.	1345	RESUBMIT CLAIM WITH ELIGIBLE MEDICAID RECIPIENT ID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	0051	RENAL REVENUE IS PRESENT - RENAL BILL TYPE IS MISSING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	0054	INPATIENT/INPATIENT CROSSOVER CLAIM - SWING BEDS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	0123	EMC CLM NOT ALLOWED FOR SR GOLD CLM SUBMIT BY POS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	0190	1ST 2 POSITIONS OF BILL TYPE CONFLICTS WITH THE PAYOR ID	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (10/16/03)	Missing/incomplete/invalid type of bill.	0435	UNABLE TO DETERMINE HIPAA CLAIM TYPE.	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0022	INV/MISS BILLED DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0041	ADMISSION DATE > SERVICE COVERS FROM DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0057	CONDITION CODE 40 - FROM/THRU NOT EQUAL	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0064	SERVICE THRU DATE > STATEMENT THRU DATE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0073	SERVICE COVERS FROM DATE < STATEMENT FROM DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0074	STATEMENT COVERS FROM DATE > SERVICE THRU DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0089	DATE OF SURGERY > SERVICE/STATEMENT THRU DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0111	LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0113	LTC/HOSPICE LONG TERM PSYCH CLAIM SPANS MONTHS'	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0220	CLAIM SPANS FISCAL YEAR	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0334	DATE OF CONS MUST BE AT LEAST 30 BUT NOT > 180 DAYS FROM DOS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0401	DATE OF SERVICE < DATE OF BIRTH	14 (10/16/03)	The date of birth follows the date of service.
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0530	LTC OVERLAPPING LEAVE PERIODS	226 (01/01/14)	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.)
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	0620	RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK	141 (01/01/14)	Claim spans eligible and ineligible periods of coverage.
MA31 (09/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.	1408	HOSPICE CUTBACK DAY OF REVOCATION	238 (09/01/14)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
MA31 (06/29/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	1409	HOSPICE DATE OF DEATH PAYMENT CUTBACK	238 (06/29/15)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
MA31 (01/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.	1640	HOSPICE TRANSFER DAY OF DISCHARGE PAYMENT CUTBACK	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.	0157	ACUTE DAYS > 150 - RESUBMIT AS INPATIENT TPL CLAIM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.	0158	ACUTE DAYS > 90 - RESUBMIT AS INPATIENT TPL CLAIM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA33 (10/16/03)	Missing/incomplete/invalid non-covered days during the billing period.	0067	INV/MISS NON COVERED HOSPITAL DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	0173	INVALID COINSURANCE DAYS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	0179	MISSING/INVALID COINSURANCE DAYS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	0510	COINS DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA34 (11/01/15)	Missing/incomplete/invalid number of coinsurance days during the billing period.	1252	MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.	0154	COINS AND/OR LIFETIME RESERVE DAYS CONFLICT WITH DOS	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.	0155	COINS DAYS LIFETIME RESERVE DAYS AND/OR BLD DEDUCT MISSING	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA35 (11/01/15)	Missing/incomplete/invalid number of lifetime reserve days.	0156	COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA36 (10/16/03)	Missing/incomplete/invalid patient name.	0012	MISSING RECIPIENT NAME	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA36 (01/01/14)	Missing/incomplete/invalid patient name.	0302	NAME MISMATCH OR FOR PHARMACY: GENDER AND/OR DOB	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA36 (01/01/14)	Missing/incomplete/invalid patient name.	1205	ADJUSTMENT/VOID DOES NOT MATCH RECIPIENT ID ON CLAIM	129 (01/01/14)	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.)
MA39 (06/18/07)	Missing/incomplete/invalid gender.	1803	CLAIM CHECK: INVALID OR MISSING GENDER	7 (12/12/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA39 (11/01/15)	Missing/incomplete/invalid gender.	1829	CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (10/16/03)	Missing/incomplete/invalid admission date.	0040	INV/MISS ADMISSION DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (11/01/15)	Missing/incomplete/invalid admission date.	0515	NURSING FACILITY ADMIT RESTRICTED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (10/16/03)	Missing/incomplete/invalid admission date.	0635	LTC NEW ADMIT DATE OF SERVICE PRIOR TO ASSESSMENT DATE	26 (10/16/03)	Expenses incurred prior to coverage.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA41 (10/16/03)	Missing/incomplete/invalid admission type.	0044	INV/MISS TYPE OF ADMISSION	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA42 (10/16/03)	Missing/incomplete/invalid admission source.	0068	INVALID SOURCE OF ADMISSION	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA42 (10/16/03)	Missing/incomplete/invalid admission source.	0084	BABY & MOTHER-ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (11/01/15)	Missing/incomplete/invalid patient status.	0001	GENERIC ELIGIBILITY RECORD USED.	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	0045	INV/MISS PATIENT STATUS CODE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	0367	GA RECIPIENT INELIGIBLE ON DATE OF SERVICE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	0419	WFNJ/GA OR NJFL CLAIM PROCESSED AS ADDP	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	0420	CLAIM PAYABLE UNDER WFNJ/GA OR FC ONLY	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (01/01/14)	Missing/incomplete/invalid patient status.	1654	RECIPIENT INELIGIBLE FOR ACA TITLE 19	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.	0346	INVALID/MISSING STERILIZATION INTERPRETER INDICATOR	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.	0347	INVALID/MISS STERILIZATION RACE CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA61 (11/01/15)	Missing/incomplete/invalid social security number.	0398	GA RECIPIENT ID CHANGED TO MEDICAID RECIPIENT ID.	31 (11/01/15)	Patient cannot be identified as our insured.
MA63 (11/01/15)	Missing/incomplete/invalid principal diagnosis.	0294	DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.	0919	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.
MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.	0920	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.
MA64 (11/01/15)	Our records indicate that we 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.	1645	HMS MEDICARE COVERAGE IS NOT PRESENT ON TPL	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA64 (11/01/15)	Our records indicate that we 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.	1646	HMS PRIVATE COVERAGE IS NOT PRESENT ON THE TPL	22 (11/01/15)	This care may be covered by another payer per coordination of benefits.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA65 (10/16/03)	Missing/incomplete/invalid admitting diagnosis.	0114	INV/MISS ADMIT CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA65 (11/01/15)	Missing/incomplete/invalid admitting diagnosis.	1288	INVALID/MISSING UB04 ADMIT DIAGNOSIS	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	0161	INV/MISS HCPCS PROCEDURE CODE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	0248	SURGERY PROCEDURE CODE NOT ON FILE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	0345	MISSING ABORTION PROCEDURE CODE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (11/01/15)	Missing/incomplete/invalid principal procedure code.	0666	UNABLE TO PRICE CLAIM	107 (11/01/15)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA67 (05/04/21)	Alert: Correction to a prior claim.	1466	REPROCESSED AT THE REQUEST OF MFD - WITHOUT A UD MODIFIER	129 (05/04/21)	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.)



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA67 (03/20/23)	Alert: Correction to a prior claim.	1470	RECYCLED AFTER CHANGE OF OWNERSHIP - ALM 3708	129 (03/20/23)	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.)
MA67 (06/08/15)	Alert: Correction to a prior claim.	1674	REPROCESS PE CLAIMS NOW ELIGIBLE FOR NEW ADULT GROUP	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA70 (01/01/14)	Missing/incomplete/invalid provider representative signature.	0360	PHYSICIAN SIGNATURE/DATE MISSING ON SECOND OPINION FORM	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA71 (11/01/15)	Missing/incomplete/invalid provider representative signature date.	0356	RECIP/PHYS DATE/SIGN MISSING ON STERILIZATION FORM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA75 (01/01/14)	Missing/incomplete/invalid patient or authorized representative signature.	0342	RECIPIENT DATES, SIGNATURE MISSING ON HYSTER FORM	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0917	MODERATE DRUG/DRUG INTERACTION DUR	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0918	DAILY DOSAGE EXCEEDS MAXIMUM RECOMMENDED DOSAGE	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0921	SEVERE DRUG/DRUG INTERACTION - NO PA OVERRIDE CAPABILITY	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0922	DRUG INDICATES PREGNANCY PRECAUTION WARNING	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0923	DAILY DOSAGE LESS THAN MINIMUM RECOMMENDED DOSAGE	11 (10/16/03)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0941	SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM	3 (10/16/03)	Co-payment Amount
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	0987	DEDUCT AMT INCLUDES MEDICARE OR PRIVATE INS REFUND TO STATE	B10 (10/16/03)	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.
MA80 (04/01/18)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	1625	COMMERCIAL HMO CO-PAY/COINS/DEDUCT	3 (04/01/18)	Co-payment Amount



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA81 (01/01/14)	Missing/incomplete/invalid provider/supplier signature.	0344	PHYSICIAN SIGN/NUMBER/DATES MISSING ON ABORTION FORM	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA92 (09/01/20)	Missing plan information for other insurance.	0443	TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA92 (01/01/14)	Missing plan information for other insurance.	0946	RA SHOWING MEDICAID CROSSOVER PAYMENT MUST BE ATTACHED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	0325	SERVICE NOT COVERED BY HMO - RECIPIENT INELIG FOR MEDICAID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	0328	MHC RECIPIENT-NO M'CAID ELIG SEGMENT FOR THIS PERIOD	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	0330	HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	0508	PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N3 (01/01/16)	Missing consent form.	0196	TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER	163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.
N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0171	INVALID CARRIER CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0943	REBILL CLAIM WITH MEDICARE PAID LINES ONLY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0947	MEDICARE OUTPATIENT PART B EOB MISSING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0948	EOB MISSING FOR CARRIER/PAYOR REPORTED ON CLAIM	251 (01/01/14)	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).
N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0959	CLAIM UPDATED WITH TPL PAYMENT	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0965	MEDICARE INPATIENT PART A EOB MISSING	252 (01/01/14)	An attachment/other documentation 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).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0966	MEDICARE INPATIENT PART B EOB MISSING	252 (01/01/14)	An attachment/other documentation 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).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0967	MEDICARE PHYSICIAN PART B EOB MISSING	252 (01/01/14)	An attachment/other documentation 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).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0971	MISSING CARRIER CODE/PAYOR ID	251 (01/01/14)	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).
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0972	NO EOB ATTACHED-RECIPIENT WITH OTHER RESOURCE INDICATED	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0973	CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0974	TPL PAYMENT AMOUNT FROM EOB MISSING ON CLAIM	251 (01/01/14)	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).
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0980	EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0982	EOB INDICATES BILLING ERROR, REVIEW OR REBILL TO CARRIER	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	0985	ENTER TPL AMT PAID FROM EOB IN PRIOR PMT BOX ON CLAIM FORM	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N5 (08/31/04)	EOB received from previous payer. Claim not on file.	0799	NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N8 (10/16/03)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	0174	CLAIM IS NOT XOVER - RESUBMIT AS INPATIENT HOSPITAL CLAIM	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N8 (11/01/15)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	1636	MEDICARE CROSSOVER CLAIM PAID AND DUPLICATE DME CLAIM VOIDED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.	0798	HISTORY RECORD ALREADY ADJUSTED OR VOIDED	129 (10/16/03)	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.)
N9 (11/29/21)	Adjustment represents the estimated amount a previous payer may pay.	1038	PROVIDER NOT COVERED FOR OORP SERVICES	96 (11/29/21)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0234	PEND FOR OUT-OF-STATE NON-DRG PRICING POLICY CHANGE	55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0458	OCCURRENCE CODE INDICATES ACCIDENT REVIEW REQUIRED	55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0550	PENDING FOR REVIEW OF DRUG FILE ENTRY	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0605	OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING	40 (04/01/18)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0608	PEND FOR MANUAL PRICING	40 (11/01/15)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0617	CALCULATED PAYMENT AMOUNT ZERO	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0710	UNABLE TO DETERMINE LEAVE PERIOD-ADJUSTMENT MAY BE REQUIRED	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0732	ADJUSTMENT TO DENTURES WITHIN 6 MONTHS OF DELIVERY	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0788	ADJUSTMENT DENIED/ORIG PAID CORRECTLY	B20 (11/01/15)	Procedure/service was partially or fully furnished by another provider.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0790	INVALID ADJUSTMENT LOCATOR	96 (01/01/16)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0791	ADJUSTMENT REQUIRES MANUAL UPDATE	151 (09/01/20)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0792	ADJUSTMENT TO CONVERTED CLAIM	150 (01/01/16)	Payer deems the information submitted does not support this level of service.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0793	ADJUSTMENT PENDED FOR ARCHIVE CYCLE	151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0844	ADJUSTMENT CLAIM MISSING PAYOR CODE AND/OR PRIOR PAYMENT	65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	0846	ADJUSTMENT MUST HAVE RA ATTACHED	65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1202	PREMIUM SUPPORT PROGRAM - STATE REVIEW REQUIRED.	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1279	CALCULATED PAYMENT AMOUNT ZERO	150 (11/01/15)	Payer deems the information submitted does not support this level of service.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1603	ADJ/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIG	51 (01/01/16)	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	1629	DENTAL ANESTHESIA CLAIM CUTBACK BY BEHAVIOR MANAGEMNT CLAIMS	269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N12 (11/01/15)	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	0285	HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0601	PAYMENT REDUCED TO MEDICAID MAXIMUM	35 (01/01/14)	Lifetime benefit maximum has been reached.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0626	PAYMENT REDUCED TO MAC MAXIMUM	B5 (01/01/14)	Coverage/program guidelines were not met or were exceeded.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0630	LTC LEAVE DAYS CUT BACK TO MAXIMUM ALLOWED	45 (03/25/15)	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0637	MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS	22 (01/01/14)	This care may be covered by another payer per coordination of benefits.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0656	MISSING NJ DRG MARKUP FACTOR	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	0882	ORTHODONTIC CUTBACK/INITIAL PAYMENT	23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
N19 (01/01/14)	Procedure code incidental to primary procedure.	0906	MULTIPLE SURGERY - \$0 PAID, INCIDENTAL PROCEDURE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N20 (11/01/15)	Service not payable with other service rendered on the same date.	0778	NO IMMUNIZATION CODE PROVIDED ON THE SAME DAY OF SERVICE	16 (07/23/04)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	0392	PROCEDURE CODE MAPPED TO LOCAL CODE FOR PROCESSING PURPOSES	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	0968	PROCEDURE CODE DOES NOT ACCURATELY REFLECT SERVICES RENDERED	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N26 (01/29/16)	Missing itemized bill/statement.	0957	CLAIM CORRECTED OR REPROCESSED BY REQUEST	250 (01/29/16)	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).



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N27 (11/01/15)	Missing/incomplete/invalid treatment number.	0101	ABNOR INDIC IN THE PHYS/SCR IND NEW/PRIOR COND INVAL/MISS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N27 (11/01/15)	Missing/incomplete/invalid treatment number.	0348	INVALID ABORTION CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N28 (11/01/15)	Consent form requirements not fulfilled.	0353	ATTACHED FORM DATA INCORRECT/MISSING/ILLEGIBLE	252 (11/01/15)	An attachment/other documentation 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).
N29 (10/16/03)	Missing documentation/orders/notes/summary/report/chart.	0996	NO APPROP CODES ASSIGNED FOR CREDIT RECORD	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N30 (10/16/03)	Patient ineligible for this service.	0263	NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0301	RECIPIENT INELIG ON DATES OF SERVICE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (01/01/14)	Patient ineligible for this service.	0305	CCPED OR HCEP NON COVERED SERVICE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (09/01/20)	Patient ineligible for this service.	0308	INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	0309	GSHP OUT-OF-PLAN SERVICE- RECIPIENT INELIGIBLE FOR MEDICAID	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/01/15)	Patient ineligible for this service.	0332	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21	167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0350	GENERAL ASSISTANCE-SERVICE NOT COVERED.	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0365	GA RECIPIENT NOT ON RECIP HISTORY MASTER FILE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/03/03)	Patient ineligible for this service.	0370	PLAN H - BENEFICIARY - NON-COVERED SERVICE.	96 (11/04/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (11/01/15)	Patient ineligible for this service.	0371	CSOCI - UNABLE TO DETERMINE COVERAGE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0373	CSOCI - NON-COVERED SERVICE	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0385	NON-COVERED SERVICE FOR PROGRAM STATUS CODE	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/01/15)	Patient ineligible for this service.	0399	GA RECIPIENT ID CHANGED.	26 (11/01/15)	Expenses incurred prior to coverage.
N30 (10/16/03)	Patient ineligible for this service.	0432	THIS LEGEND DRUG NOT COVERED BY PAAD/SG	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0450	DRUG NOT COVERED FOR ESRD RECIPIENT	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0451	MEDICAL SUPPLY OR SERVICE(S) NOT COVERED FOR ESRD RECIPIENT	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (10/16/03)	Patient ineligible for this service.	0456	LAB NOT COVERED FOR ESRD RECIPIENT	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	0506	RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N30 (11/01/15)	Patient ineligible for this service.	0521	RECIP NOT ON LTC MASTER FILE	26 (11/01/15)	Expenses incurred prior to coverage.
N30 (11/01/15)	Patient ineligible for this service.	0525	LTC PASARR APPROVAL TERMINATED	27 (11/01/15)	Expenses incurred after coverage terminated.
N30 (11/01/15)	Patient ineligible for this service.	0528	LTC RECIP NOT ELIG FOR ENTIRE PERIOD-CUTBACK ASSESSMENT DTE	27 (11/01/15)	Expenses incurred after coverage terminated.
N30 (10/16/03)	Patient ineligible for this service.	0532	NON LEGEND DRUG NOT COVERED FOR PAAD/SR GOLD BENEFICIARIES	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0534	DRUG NOT PAYABLE FEDERAL/IRS DESI	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0552	ADDP-SERVICE NOT COVERED.	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	0555	PAAD RECIP INELIGIBLE FOR MEDICAID SERVICES	150 (10/16/03)	Payer deems the information submitted does not support this level of service.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (10/16/03)	Patient ineligible for this service.	0561	COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	0581	DENTAL SERVICES AFTER ELIGIBILITY TERMINATION	27 (01/01/14)	Expenses incurred after coverage terminated.
N30 (10/01/19)	Patient ineligible for this service.	1011	NOT A FAMILY PLANNING SVC/NOT ATTESTED PLANNING SVC	204 (10/01/19)	This service/equipment/drug is not covered under the patient's current benefit plan
N30 (10/01/08)	Patient ineligible for this service.	1318	DOC RECIPIENT INELIG ON DATE OF SERVICE	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N30 (10/01/08)	Patient ineligible for this service.	1319	DOC RECIPIENT NOT ON FILE	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N30 (05/15/17)	Patient ineligible for this service.	1447	RECIPIENT INELIGIBLE FOR CSOC RESPITE SERVICE	96 (05/15/17)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/10/14)	Patient ineligible for this service.	2290	PHARMACY CLAIM NOT PAYABLE FOR SPC 98 OR 99	258 (01/29/16)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N31 (01/01/14)	Missing/incomplete/invalid prescribing provider identifier.	0004	INV/MISS PRESCRIBER'S MEDICAID ID NUMBER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	1233	NPI MISSING FOR PRESCRIBING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	1267	NPI NOT CROSSWALKED - PRESCRIBING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	1268	PROVIDER NOT MATCHED- PRESCRIBING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/09/11)	Missing/incomplete/invalid prescribing provider identifier.	1309	SUPERVISING PROVIDER NOT ON FILE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (01/01/13)	Missing/incomplete/invalid prescribing provider identifier.	1387	PROVIDER ID AND NPI REQUIRED - PRESCRIBING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.	1413	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - PRESCRIBING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.	1423	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - PRESCRIBING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (01/01/19)	Missing/incomplete/invalid prescribing provider identifier.	2298	SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N32 (11/01/15)	Claim must be submitted by the provider who rendered the service.	0522	INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N32 (06/18/07)	Claim must be submitted by the provider who rendered the service.	1862	CLAIM CHECK: MISSING PROVIDER ON CLAIM	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	0288	VETERANS HOME RESIDENT, NON COVERED SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N34 (11/01/15)	Incorrect claim form/format for this service.	0340	ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (01/01/14)	Incorrect claim form/format for this service.	0357	HYSTERECTOMY RECEIPT OF INFO FORM-DATA INCORR/MISS OR ILLEG	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	0944	PROCEDURE CODE AND/OR CHARGES ON CLAIM DO NOT MATCH EOB	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	0998	INCORRECT PAAD CLAIM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	0223	PROVIDER ON REVIEW-DENY PAYMENT	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N35 (11/01/15)	Program integrity/utilization review decision.	0280	POS PAID CLAIM, PAYMENT PENDING	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	0315	HOSPICE ELECTION REVIEW	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	0316	LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	0375	SPECIAL STATE AUTO PEND	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	0379	SPEC PGM UNABLE TO DETERMINE COVERAGE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	0426	NO FQHC ENCOUNTER WITH DELIVERY HCPCS CLAIM PAID AT NON-ZERO	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	0651	MISSING PENNSYLVANNIA DRG RATE DATA	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N35 (10/16/03)	Program integrity/utilization review decision.	0652	MISSING NEW YORK DRG RATE DATA	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N35 (10/16/03)	Program integrity/utilization review decision.	0653	MISSING NY DRG SERVICE INTENSITY WEIGHT	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N35 (10/16/03)	Program integrity/utilization review decision.	0654	MISSING NY DRG OUTLIER PERCENT	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N35 (10/16/03)	Program integrity/utilization review decision.	0655	MISSING NEW YORK DRG ALC PER DIEM RATE	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: 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).
N35 (10/16/03)	Program integrity/utilization review decision.	0888	CLAIM VOIDED DUE TO STATE AUDIT - SEE REMITTANCE MESSAGE 624	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
N35 (01/01/14)	Program integrity/utilization review decision.	0925	UTILIZATION REVIEW APPROVAL MISSING/INCORRECT/DENIED	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	0942	CLAIM VOIDED DUE TO POST-PAYMENT REVIEW BY MUNICIPALITY.	A1 (10/16/03)	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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N36 (11/01/15)	Claim must meet primary payer's processing requirements before we can consider payment.	0391	PREMIUM SUPPORT - BILL OTHER INSURANCE	109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N37 (11/01/15)	Missing/incomplete/invalid tooth number/letter.	0587	MISSING/INVALID TOOTH NUMBER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	0116	INVALID LEAVE OF ABSENCE DATE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	0117	LEAVE OF ABSENCE DATE(S) OUTSIDE DATES OF SERVICE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	0118	LEAVE OF ABSENCE FROM/THRU DATE CONFLICT	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	0121	MCARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	0122	MCARE BED HOLD END DATE OUTSIDE DATES OF SERVICE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N43 (11/01/15)	Bed hold or leave days exceeded.	0509	MEDICARE BED HOLD INVALID	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	0718	HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	0719	THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/16)	Bed hold or leave days exceeded.	0833	CLAIM FOR CONTINUOUS LEAVE- NO PRIOR SERVICE DATE PAID CLAIM	96 (01/01/16)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	0930	BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	0932	THERAPEUTIC LEAVE EXCEEDS MAXIMUM OF 24 CONSECUTIVE DAYS	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (11/01/15)	Bed hold or leave days exceeded.	0933	THERAPEUTIC LEAVE CUTBACK TO 24 DAYS MAXIMUM	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N43 (01/01/14)	Bed hold or leave days exceeded.	0934	BED-HOLD CUTBACK TO 10 DAY MAXIMUM	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (07/01/07)	Bed hold or leave days exceeded.	1248	NO BED HOLD/THERAPEUTIC LEAVE PAYMT FOR NURSING FACILITY	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N45 (11/01/15)	Payment based on authorized amount.	0289	PAYMENT BASED ON THE PLACE OF SERVICE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N45 (10/16/03)	Payment based on authorized amount.	0526	PA-3L INCOME GREATER THAN PATIENT PAYMENT AMOUNT PA-3L USED	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
N45 (01/01/08)	Payment based on authorized amount.	1258	SERVICES PAID AT CHILDREN'S RATE	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N45 (11/01/15)	Payment based on authorized amount.	1335	PAYMENT REDUCED TO SUL PRICE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N45 (04/01/17)	Payment based on authorized amount.	2297	CLAIM SUBMITTED AS A 340B CLAIM	119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.
N46 (10/16/03)	Missing/incomplete/invalid admission hour.	0063	INV/MISS ADMISSION HOUR	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N46 (09/07/10)	Missing/incomplete/invalid admission hour.	1286	INVALID UB04 OCCURRENCE SPAN THRU DATE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N48 (01/01/14)	Claim information does not agree with information received from other insurance carrier.	0787	ADJUSTMENT CLAIM TYPE NOT MATCHED	129 (01/01/14)	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.)
N50 (10/16/03)	Missing/incomplete/invalid discharge information.	0115	INVALID GENERAL STATUS / DISCHARGE CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N50 (10/16/03)	Missing/incomplete/invalid discharge information.	0119	INV/MISS LEAVE OF ABSENCE CODE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N50 (10/16/03)	Missing/incomplete/invalid discharge information.	0514	NURSING FACILITY LEAVE/RETURN RESTRICTED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.	0600	LTC RECIPIENT NOT ELIGIBLE ON DATE(S) OF SERVICE	26 (11/01/15)	Expenses incurred prior to coverage.
N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.	1381	ACTIVE MANAGED CARE FOUND W/O ACTIVE ELIGIBILITY	256 (11/01/15)	Service not payable per managed care contract.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.	0410	SERVICE NOT AUTHORIZED BY GSHP CASE MANAGER	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.	0776	PA DOLLARS/UNITS EXHAUSTED-CUTBACK	198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.	0784	GSHP PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED	198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (01/01/14)	Claim information is inconsistent with pre-certified/authorized services.	1600	CLAIM EXCEEDS BEDS LICENSED TO PROVIDER FOR THE MONTH	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.	1617	PA NUMBER CHANGED SYSTEMATICALLY	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.
N55 (09/10/13)	Procedures for billing with group/referring/performing providers were not followed.	0993	CLAIM DENIED AT PROVIDER REQUEST	P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0048	MISSING/INV SURGICAL PROCEDURE CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0150	INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON 1500NJ	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0163	PROCEDURE - SPANNING DATES OF SERVICE	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0238	PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0247	REVENUE/ICD9/HCPACS PROC CODE ON CLM CONFLICTS WITH CLM TYPE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0273	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0584	MODIFIER REMOVED - TRIP LESS THAN 16 MILES	4 (10/16/03)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	0724	DATE(S) OF SERVICE DO NOT MATCH LAB PANEL PROCEDURE EFF DATE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (01/01/16)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1438	HOSPICE SERVICE INTENSITY ADD-ON LIMIT EXCEEDED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N57 (10/16/03)	Missing/incomplete/invalid prescribing date.	0025	INV/MISS DISPENSED DATE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N58 (11/01/15)	Missing/incomplete/invalid patient liability amount.	0136	COPAY CLAIM DENIED - NO BENEFICIARY OR PROGRAM LIABILITY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N58 (09/01/20)	Missing/incomplete/invalid patient liability amount.	0698	COINSURANCE DAYS EXCEED MEDICARE MAXIMUM OF 30 DAYS	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	0300	HMO-COVERED SERVICE	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	0413	2 PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION	153 (10/16/03)	Payer deems the information submitted does not support this dosage.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	0414	1 PRESCRIPTION REMAINS WITHOUT NEED FOR PRIOR AUTHORIZATION	153 (10/16/03)	Payer deems the information submitted does not support this dosage.
N59 (04/01/18)	Alert: Please refer to your provider manual for additional program and provider information.	0415	NO PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION	153 (04/01/18)	Payer deems the information submitted does not support this dosage.
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	0539	THIS LIVERY SVC IS ONLY VALID IN COUNTIES 07, 09 AND 90	A1 (10/16/03)	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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	0571	CAPITATION INDICATOR NOT MATCHED	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	0572	INVALID CAP CODE	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	0662	CLAIM PRICED-CHARGE TO MCAID AS PERCENT OF TOTAL CLM CHARGE	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	1021	CAPITATION PAYMENT REDUCED BY FULL PATIENT LIABILITY	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	1024	CAPITATION PAYMENT REDUCED BY PARTIAL PATIENT LIABILITY	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	1026	CAPITATION PAYMENT REDUCED FOR ELIGIBILITY LIMITS	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	1380	GHI CROSSOVER - SERVICE IS IN-PLAN (MANAGED CARE)	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N61 (11/01/15)	Rebill services on separate claims.	0319	INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N61 (11/01/15)	Rebill services on separate claims.	0908	UNABLE TO PRICE MULTIPLE SURGERY CLAIM	267 (11/01/15)	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N62 (01/01/14)	Dates of service span multiple rate periods. Resubmit separate claims.	0284	PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N62 (11/01/15)	Dates of service span multiple rate periods. Resubmit separate claims.	1209	DOS SPANS PROVIDER FISCAL YR, MULTIPLE RATE USED FOR PRICING	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N62 (01/01/16)	Dates of service span multiple rate periods. Resubmit separate claims.	1443	HOSPICE DOS OVERLAP THE FIRST 60 DAYS OF HOSPICE CARE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N63 (11/01/15)	Rebill services on separate claim lines.	0642	RESUBMIT CLM WITH INVOICE OR MANUFACTURER'S PRICE LIST	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (04/01/18)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0533	OTC DRUG COST INCLUDED IN NF PER DIEM	107 (04/01/18)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0565	OTC DRUG NO UNIT PRICE ON FILE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0566	OTC DRUG NO PACKAGE PRICE ON FILE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0567	TEAMCARE DRUG NO UNIT PRICE ON FILE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0568	TEAMCARE DRUG NO PACKAGE PRICE ON FILE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0569	LEGEND DRUG NO PACKAGE PRICE ON FILE	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0574	CAPITATION RATE NOT FOUND FOR CLAIM DOS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0575	NO GSHP PCM RATE NOT FOUND FOR CLAIM SERVICE DATE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0591	PROVIDER NOT ON PROVIDER RATE FILE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0592	CAPITATION CATEGORY NOT ON GSHP RATE FILE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0593	CAPITATION CATEGORY RATE NOT IN EFFECT FOR DATE OF SERVICE	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0595	REV CODE/COND CODE CONFLICT FOR COMPOSITE RATE PRICING	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0596	PHARMACY CAPITATION RATE LEVEL NOT IN EFFECT FOR DOS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0618	VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	0619	VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE	147 (10/16/03)	Provider contracted/negotiated rate expired or not on file.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N75 (01/01/14)	Missing/incomplete/invalid tooth surface information.	0102	INV/MISS TOOTH SURFACE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N75 (10/16/03)	Missing/incomplete/invalid tooth surface information.	0582	MISSING/INVALID TOOTH SURFACE	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N75 (11/01/15)	Missing/incomplete/invalid tooth surface information.	0586	MISSING/INVALID TOOTH QUADRANT	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N77 (11/01/15)	Missing/incomplete/invalid designated provider number.	0217	LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD:CUTBACK	208 (11/01/15)	National Provider Identifier - Not matched.
N77 (11/01/15)	Missing/incomplete/invalid designated provider number.	0579	PROVIDER IRS NUM REQUIRED FOR SPECIAL EDUC CLAIM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N77 (08/16/10)	Missing/incomplete/invalid designated provider number.	1329	HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION	208 (08/16/10)	National Provider Identifier - Not matched.
N77 (08/16/10)	Missing/incomplete/invalid designated provider number.	1334	HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION	208 (08/16/10)	National Provider Identifier - Not matched.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0092	INV/MISS EPSDT IMMUNIZATION STATUS CODE(S)	251 (11/01/15)	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).
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0093	INV/MISS EPSDT SCREENING INFORMATION INDICATORS	251 (11/01/15)	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).
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0094	INV/MISS OR CONFLICTING EPSDT PHYSICAL DATA INDICATOR	251 (11/01/15)	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).
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0095	INV/MISS EPSDT RACE CODE	251 (11/01/15)	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).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0096	EPSDT ANTICIPATORY GUIDANCE MISSING OR INVALID	251 (11/01/15)	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).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0097	INVALID EPSDT PHYSICAL SCREEN INDICATOR	251 (11/01/15)	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).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0098	INVALID OR MISSING EPSDT CONTINUED CARE	251 (11/01/15)	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).



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	0099	EPSDT WIC INDICATOR INVALID OR MISSING	251 (11/01/15)	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).
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	0202	PROVIDER CANNOT SUBMIT THIS CLAIM TYPE	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	0219	PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	0221	PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	0226	BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE	243 (11/01/15)	Services not authorized by network/primary care providers.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	0229	SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO.OR MORE	243 (11/01/15)	Services not authorized by network/primary care providers.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	0237	PROCEDURE/PROVIDER SPECIALTY RESTRICTION	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	0266	NOT AN SAI COVERED SERVICE	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	0278	PROVIDER NOT AUTHORIZED THIS PROCEDURE	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	0380	CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	0381	CLAIM SUBMITTED FFS-UNABLE TO DETERMINE IN-PLAN/OUT-OF-PLAN	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	0590	PROC CODE BILLED IS ONLY PAYABLE TO A SPECIALIST	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (01/28/05)	This provider type/provider specialty may not bill this service.	0690	PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM.	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	0697	CLAIM PENDED PROVIDER RE-ENROLLMENT NOT COMPLETED	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (04/02/10)	This provider type/provider specialty may not bill this service.	1326	INVALID PROVIDER TYPE FOR ATTENDING PROVIDER	170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (07/01/09)	This provider type/provider specialty may not bill this service.	1327	HMO RESPONSIBLE FOR NON-ABP FACILITY COSTS	256 (11/01/15)	Service not payable per managed care contract.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	1338	ESRD BILLABLE SERVICE	256 (11/01/15)	Service not payable per managed care contract.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	1383	INVALID PROVIDER TYPE - OPERATING 1	170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	1384	INVALID PROVIDER TYPE - OPERATING 2 PHYSICIAN	170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (02/01/16)	This provider type/provider specialty may not bill this service.	1385	PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - SERVICING	170 (02/01/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (02/01/16)	This provider type/provider specialty may not bill this service.	1386	PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - BILLING	52 (01/01/13)	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N95 (02/20/17)	This provider type/provider specialty may not bill this service.	1452	NON-MEDICAID PROVIDER NOT ELIGIBLE FOR SERVICE	170 (02/20/17)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (06/26/17)	This provider type/provider specialty may not bill this service.	1453	INCORRECTLY BILLED SVC; REQUIRES HH MOD, CCBHC SVC/PROV	96 (06/26/17)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/06/18)	This provider type/provider specialty may not bill this service.	1455	NOT A COVERED SERVICE UNDER NJ MEDICAID	170 (08/06/18)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N103 (11/01/15)	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local Authority as appropriate.	1316	CLAIMS FOR DEPARTMENT CORRECTIONS INMATE	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N104 (10/16/03)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0484	ESRD POSSIBLY ELIGIBLE FOR MEDICARE	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0682	SERVICE/PRODUCT NOT ELIGIBLE UNDER MEDICAID PROGRAM	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0884	CLAIM DENIED/SUBMIT DME CLAIM TO MEDICARE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0945	'CARE ASSIGNMENT NOT ACCEPTED - CLAIM NOT PAYABLE BY 'CAID	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0963	RECIPIENT HAS MEDICARE - BILL MEDICARE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0970	BILL THIRD PARTY CARRIER OR MEDICARE HMO FIRST	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	0979	RECIPIENT IS MCARE PART B OR MCARE HMO ELIGIBLE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	1006	CLAIM IS 100% MEDICARE-COVERED - NO MEDICAID PAYMENT DUE	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .	1836	CLAIM CHECK: CLAIM WAS BYPASSED	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N109 (08/01/15)	Alert: This claim/service was chosen for complex review.	0958	DENIED ACCORDING TO MEDICAID/MEDICAL REVIEW GUIDELINES	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0701	DUPLICATE CONSULTATION	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0795	CLAIM ADJUSTED BY SYSTEM - NEW ICN	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0805	INPATIENT AND HOME HEALTH DUPLICATE ERROR	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0806	LTC AND HOME HEALTH DUPLICATE ERROR	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0827	PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0840	EXACT DUPLICATE WITHIN GROUP PRACTICE	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (01/01/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0951	POSSIBLE DUPLICATE CCF - SEE RA MESSAGE #300	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0954	CLAIM REPROCESSED TO CORRECT PAYMENTOR	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	0956	CLAIM REPROCESSED TO CORRECT PAYMENT	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)



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N111 (01/01/13)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	1878	CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0236	PROCEDURE/PLACE OF SERVICE RESTRICTION	58 (01/01/14)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0242	SPECIAL PROGRAM/PROGRAM STATUS CODE-PROCEDURE RESTRICTION	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0244	INVALID PROGRAM STATUS FOR SEMI PROCEDURES	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0299	SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0427	FQHC DELIVERY HCPCS MINUS ENCOUNTER RATE.	97 (12/27/04)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	0436	SUBMITTER NOT ELIGIBLE FOR CLAIM TYPE ON ACTIVITY DATE	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (08/01/16)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	1007	SUD PLACE OF SERVICE RESTRICTION	58 (08/01/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (01/27/21)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	1468	PROC CODE RESTRICT FOR NON-ADDP RECIEP(PSC NOT EQUAL TO 780)	B5 (01/27/21)	Coverage/program guidelines were not met or were exceeded.
N115 (07/01/23)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	1472	SPECIAL PROGRAM CODE RESTRICTION FOR SERVICE DATE(S)	B5 (07/01/23)	Coverage/program guidelines were not met or were exceeded.



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N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	1831	CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE	7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	1893	CLAIM CHECK: PROCEDURE GENDER RESTRICTION	7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N122 (12/01/22)	Add-on code cannot be billed by itself.	1855	CLAIMSXTEN ADD ON EDIT	B15 (12/01/22)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	0254	PROCEDURE CODE NDC AGE RESTRICTED	6 (01/01/14)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	0351	RECIP AGE AT THE TIME OF STERILIZATION CONSENT DTE < 21	6 (11/01/15)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	0358	SECOND OPINION - DATE RESTRICTION	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	0359	SECOND OPINION DATE AND AGE RESTRICTION	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N129 (11/01/15)	Not eligible due to the patient's age.	0524	INVALID LTC PSYCH RECIPIENT AGE	50 (11/01/15)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/21)	Not eligible due to the patient's age.	1705	DOULA VISIT EXCEEDS AGE LIMIT	6 (01/01/21)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	1825	CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	1826	CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	1827	CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	1828	CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT	6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	1881	CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED	6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0009	SERVICES NOT COVERED FOR THIS RECIPIENT.	96 (10/16/03)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0268	ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE	269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0303	RECIPIENT IS SERVICE OR PROVIDER RESTRICTED	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan



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N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0304	PRESUMPTIVELY ELIGIBLE RECIPIENT (NON-COVERED)	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0310	GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0404	DURATION STANDARD EXCEEDED - POSSIBLE CUTBACK	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0535	DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION PERIOD AUTHORIZED	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0536	DAILY QUANTITY POSSIBLY EXCEEDED	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0537	DAILY DRUG QUANTITY EXCEEDED; IMMEDIATE PA REQUIRED	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0538	DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0615	DRG NOT EFFECTIVE ON CLAIM SERVICE DATE	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0667	COMPUTED DRUG COST ALLOW IS ZERO - VERIFY/CORRECT QUANTITY	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0715	MENTAL HEALTH SERVICES OVER \$400-NF/BOARDING HOME	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0716	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0730	SPECIMEN COLLECTION GREATER THAN ONE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0738	REFILL EXCEEDS PROGRAM MAXIMUM	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0753	SURGERY/VISIT CONFLICT	49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0760	NORPLANT EXCEED 2 IN 5 YEARS - SAME PROVIDER	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0761	NORPLANT EXCEEDS 2 IN 5 YEARS - DIFFERENT PROVIDER	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0764	PARTIAL CARE AND FULL DAY NOT PAYABLE ON SAME DAY	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0765	DELIVERY/ABORTION PROCEDURE LIMITS	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0766	WAIVER SERVICE CONFLICT	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0767	PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0834	TBI COUNSELING EXCEEDS \$600/MNTH	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0835	TBI TRANSPORTATION EXCEEDS \$100/WK	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0836	TBI ENVIRONMENTAL MOD EXCEEDS \$5000/MNTH	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0849	RENTAL DENIED/PRIOR PURCHASE WITHIN 24 MONTHS	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0851	DME RENTAL LIMIT 6 IN 24 MONTHS EXCEEDED	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0852	DME RENTAL LIMIT 10 IN 24 MONTHS EXCEEDED	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0853	PURCHASE DENIED/6 PRIOR RENTALS WITHIN 24 MONTHS	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0854	PURCHASE DENIED/10 PRIOR RENTALS IN 24 MONTHS	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0855	PURCHASE DENIED/PRIOR PURCHASE WITHIN 24 MONTHS	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0900	ZERO PAYMENT - INFORMATIONAL EPSDT CLAIM ONLY	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0938	VOIDED CLAIM EXCEEDS PROGRAM LIMITS	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	0953	CLAIM VOIDED - SERVICE BILLED INCORRECTLY	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1367	HMS COMMERCIAL TPL RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1368	HMS COMMERCIAL TPL RECOVERY-PROVIDER ADJUSTMENTS ALLOWED	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1369	HMS CREDIT BALANCE RECOVERY - EXCESS PAY	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1370	HMS CREDIT BALANCE RECOVERY - READMISSION	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1371	HMS CREDIT BALANCE RECOVERY - TRANSFER	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1372	HMS CREDIT BALANCE RECOVERY - DUPLICATE PAYMENT	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1407	NOT A COVERED SERVICE UNDER MSP FOR SLMB OR QI	204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1467	NOT A COVERED SERVICE UNDER MSP FOR QMB	204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1609	LONG TERM PSYCHIATRIC CLAIM REDUCED BY PR1	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	1611	PARTIAL PR-1 DEDUCTION APPLIED	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2032	DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan



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N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2035	INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2151	RX IS A COMPOUND, NOT BILLED AS A COMPOUND	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2157	DOC HAS NO DIRECTIONS (SIG) FOR USE/EXCESSIVE QTY OF DAYS	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2323	DAILY MORPHINE MILLIGRAM EQUIVALENT > 50	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	2324	DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	0024	POS REVERSAL REJECTED-RESUBMIT USING FD-999 FORM.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	0786	PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED-RESUBMIT CLAIM	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N142 (01/01/16)	The original claim was denied. Resubmit a new claim, not a replacement claim.	0955	CLAIM VOIDED - RESUBMITTED AS ORIGINAL CLAIM	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	0999	PROCESSING ERROR/CLAIM WAS RESUBMITTED BY FISCAL AGENT	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N147 (11/01/15)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	0326	LTC RECIPIENT NOT ON FILE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	0513	LTC CROSSOVER CLAIM REQUIRES A MEDICARE PER DIEM RATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	0612	PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N157 (01/01/14)	Transportation to/from this destination is not covered.	0739	TRANSPORT CLAIM MUST PAY FIRST	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N163 (11/01/15)	Medical record does not support code billed per the code definition.	0126	COMPOUND DRUG INDICATOR INVALID	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	0106	CONSECUTIVE LEAVE TYPES-OVERLAPPING DATES OF SERVICES	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	0643	OUT OF REGION NON-DRG HOSPITAL REQ MAN PRICING FOR DOS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	0644	OUT OF REG NON-DRG HOSP REQ MAN PRICING-NO PROV RATE RECORD	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	1669	NO RECORD OF AN EPISODE OF CARE ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N174 (05/01/16)	This is not a covered service/procedure/equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	0629	PATIENT LIABILITY CONFLICT - PAYMENT REDUCED	96 (05/01/16)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N174 (01/01/14)	This is not a covered service/procedure/equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	1624	PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N175 (11/01/15)	Missing review organization approval.	0264	SPECIAL PROGRAM CODE - REVIEW ATTACHMENT	252 (11/01/15)	An attachment/other documentation 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).
N175 (11/01/15)	Missing review organization approval.	0338	HYSTERECTOMY PROC REQ REVIEW OF HYST RECEIPT OF INFO FORM	250 (11/01/15)	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).
N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.	0042	INV/MISS TYPE BILL CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.	0658	NO PROVIDER RATE RECORD FOR BILLING PROVIDER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.	1439	ROUTINE HOME CARE HOSPICE WITH MOD 22 PRICED AT LOWER RATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.	1444	SERVICE INTENSITY ADD-ON PROCEDURE BEYOND 7 DAYS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N193 (11/01/15)	Alert: Specific federal/state/local program may cover this service through another payer.	1313	INVALID CLAIM TYPE FOR DEPT OF CORRECTIONS	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N199 (11/01/15)	Additional payment/recoupment approved based on payer-initiated review/audit.	0991	STATE APPROVED PAYMENT	B12 (11/01/15)	Services not documented in patient's medical records.
N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.	0170	EXCESSIVE ANESTHESIA UNITS - PEND FOR MEDICAL REVIEW	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.	0195	CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.	0191	REVIEW RA MESSAGE PAGE FOR EXPLANATION	250 (11/01/15)	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).
N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.	1604	NO FQHC DELIVERY, OB/GYN OR ENCOUNTER MATCHING CLAIM	250 (11/01/15)	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).
N206 (11/01/19)	The supporting documentation does not match the information sent on the claim.	1685	NO FQHC GROUP COUNSELING MATCHING CLAIM	250 (11/01/19)	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).
N207 (11/01/15)	Missing/incomplete/invalid weight.	0043	INV/MISS BIRTH WEIGHT	240 (11/01/15)	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N207 (11/01/15)	Missing/incomplete/invalid weight.	0496	INVALID BIRTH WEIGHT / DRG	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N207 (09/09/13)	Missing/incomplete/invalid weight.	1344	BIRTH WEIGHT ON CLAIM AND DRG CONFLICT	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	0198	VERIFY AND/OR CORR DRG CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	0602	MISSING OR INVALID DRG CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	0609	DRG DIRECT COST, LOW TRIM OR HIGH TRIM PER DIEM EQUAL ZERO	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (01/01/14)	Missing/incomplete/invalid DRG code.	0621	DRG CODE NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N208 (05/01/16)	Missing/incomplete/invalid DRG code.	0657	MISSING NJ DRG PAYOR FACTOR	16 (05/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	0661	INV/MISS DRG CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N213 (11/01/15)	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	0647	MISSING PENNSYLVANIA DRG EXEMPT PER DIEM RATE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	0261	OPERATIVE/ANES. , HISTORY AND/OR PATH REPORT REQUESTED.	252 (11/01/15)	An attachment/other documentation 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).
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	0471	FQHC ENCOUNTER WITH NO PD HCPCS ON HIST	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	1610	NO MATCH FOUND IN HISTORY FOR HOSPITAL ADJUSTMENT	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N214 (06/26/17)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	1675	CCBHC ENCOUNTER WITH NO PD CCBHC ON HIST	163 (06/26/17)	Attachment/other documentation referenced on the claim was not received.
N214 (07/01/21)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	1709	OORP WEEKLY SERVICE(X4) WITH NO PD INIT SVC (X3)	163 (07/01/21)	Attachment/other documentation referenced on the claim was not received.
N214 (01/01/22)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	1710	INCK SCREENING & NO PAID ANNUAL OR E&M VISIT PAID	163 (01/01/22)	Attachment/other documentation referenced on the claim was not received.



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N216 (01/01/14)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	0270	ROUTINE IMMUNIZATION FOR HEPTITIS "A" IS NON-COVERED SERVICE	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N216 (01/01/12)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	1339	RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N221 (11/01/15)	Missing Admitting History and Physical report.	0874	ADJ/VOID AND MATCHING HISTORY CLAIM MUST BOTH BE MEDIA 7	250 (11/01/15)	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).
N221 (11/01/15)	Missing Admitting History and Physical report.	0889	GA MATCHING HISTORY NOT FOUND	250 (11/01/15)	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).
N225 (01/01/16)	Incomplete/invalid documentation/orders/notes/summary/report/chart.	0318	MED NEEDY SPENDDOWN RECIP- ATTACHMENT REVIEW	251 (01/01/16)	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).
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	0393	PAAD/SR GOLD PAYMENT BASED ON PENDING MEDICARE ENROLLMENT	22 (10/16/03)	This care may be covered by another payer per coordination of benefits.
N245 (09/01/20)	Incomplete/invalid plan information for other insurance.	0430	OTHER COVERAGE CODE VALUE IS INVALID	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	0460	INSURANCE ATTACHMENT INVALID/MISSING	251 (11/01/15)	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).
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	0848	ADJUST CLM MISSING PAYER/CARRIER CODE AND/OR TPL PAYMENT	251 (01/01/14)	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).
N245 (01/29/16)	Incomplete/invalid plan information for other insurance.	0975	RESOURCE FILE INDICATES INSURANCE OTHER THAN THAT BILLED	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
N247 (11/01/15)	Missing/incomplete/invalid assistant surgeon taxonomy.	0087	CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.	1882	CLAIM CHECK: ASSISTANT SURGEON DENIED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.	1883	CLAIM CHECK: ASSISTANT AT SURGERY DENIED	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N250 (01/01/14)	Missing/incomplete/invalid assistant surgeon secondary identifier.	0841	PROVIDER CANNOT BE SURGEON & ASST SURGEON/ANESTHESIOLOGIST	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	1296	PROVIDER ID AND NPI REQUIRED - OPERATING 2	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	1393	OPERATING 2 PROVIDER INELIGIBLE ON DATES OF SERVICE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	1399	OPERATING 2 PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N251 (09/01/20)	Missing/incomplete/invalid attending provider taxonomy.	2147	5.1 VERSION NOT ALLOWED FOR SUBMITTER APPROVED FOR D.O	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N252 (01/15/13)	Missing/incomplete/invalid attending provider name.	1223	NPI IS MISSING FOR ATTENDING PROVIDER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N252 (01/15/13)	Missing/incomplete/invalid attending provider name.	1224	NPI IS INVALID FOR ATTENDING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (01/15/13)	Missing/incomplete/invalid attending provider primary identifier.	0005	INV/MISS ATTENDING PHYSICIAN MEDICAID ID NUMBER	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (01/01/14)	Missing/incomplete/invalid attending provider primary identifier.	0200	ATTENDING PHYSICIAN NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (11/01/15)	Missing/incomplete/invalid attending provider primary identifier.	0949	CLAIM VOIDED - BILLING PROVIDER ERROR	206 (11/01/15)	National Provider Identifier - missing.
N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.	1269	ATTENDING NPI SAME AS BILLING/SERVICING NPI	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N253 (09/07/10)	Missing/incomplete/invalid attending provider primary identifier.	1295	UB04 OPERATING 2 NPI. SAME AS BILLING/SERVICE NPI.	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.	1406	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - ATTENDING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.	1419	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - ATTENDING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.	1243	NPI NOT CROSSWALKED - ATTENDING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.	1244	PROVIDER NOT MATCHED - ATTENDING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	1260	PROVIDER ID AND NPI REQUIRED - ATTENDING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	1389	ATTENDING PROVIDER INELIGIBLE ON DATES OF SERVICE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	1395	ATTENDING PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	1403	NPI NOT CROSSWALKED- ATTENDING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.	0796	BILLING PROVIDER NOT MATCHED ON HISTORY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N255 (01/01/14)	Missing/incomplete/invalid billing provider taxonomy.	0839	ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS	251 (01/01/14)	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).
N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.	1217	TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.	1218	TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.	1298	TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.	1299	TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.	1332	UNSUBMITTED TAXONOMY CODE WAS DEFAULTED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	0002	BILLING PROVIDER NUMBER MISSING/INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	0007	BILLING PROVIDER CHECK DIGIT INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (02/01/19)	Missing/incomplete/invalid billing provider/supplier primary identifier.	0204	SERVICING AND BILLING PROVIDERS NOT LINKED ON D.O.S.	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	0206	BILLING PROVIDER NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary identifier.	0230	BILLING OR SERVING PROVIDER NOT VALID	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.	1229	NPI IS MISSING FOR BILLING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.	1230	NPI IS INVALID FOR BILLING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	1404	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - BILLING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	1415	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - BILLING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	1240	NPI NOT CROSSWALKED - BILLING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	1241	PROVIDER NOT MATCHED - BILLING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N259 (01/01/13)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	1242	PROVIDER ID AND NPI REQUIRED - BILLING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.	0212	SERV PROV NOF/ LTC COTTAGE NUMBER INVALID	207 (11/01/15)	National Provider identifier - Invalid format
N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.	0216	SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED	208 (11/01/15)	National Provider Identifier - Not matched.
N262 (09/07/10)	Missing/incomplete/invalid operating provider primary identifier.	1280	NPI INVALID - UB04 OPERATING 2 PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N262 (01/15/13)	Missing/incomplete/invalid operating provider primary identifier.	1281	UB04 OPERATING 1 NPI SAME AS BILLING/SERVICING NPI.	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	1411	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 1	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	1412	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 2	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	1421	NPI NOT MAPPED WITH NEW JERSEY PROVIDER ID - OPERATING 1	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	1422	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 2	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	1227	NPI IS MISSING FOR OPERATING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	1228	NPI INVALID - UB04 OPERATING 1 PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.	1261	NPI NOT CROSSWALKED - OPERATING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.	1262	PROVIDER NOT MATCHED - UB04 OPERATING 1 PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/01/13)	Missing/incomplete/invalid operating provider secondary identifier.	1266	PROVIDER ID AND NPI REQUIRED - OPERATING 1	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N263 (09/07/10)	Missing/incomplete/invalid operating provider secondary identifier.	1282	NPI NOT CROSSWALKED-UB04 OPERATING 2 PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	1392	OPERATING 1 PROVIDER INELIGIBLE ON DATES OF SERVICE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	1398	OPERATING 1 PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N265 (01/01/14)	Missing/incomplete/invalid ordering provider primary identifier.	0224	PRESCRIBING PHYSICIAN/PRACTIONER NUMBER NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N265 (01/15/13)	Missing/incomplete/invalid ordering provider primary identifier.	1234	NPI INVALID FOR PRESCRIBING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.	1390	PRESCRIBING PROVIDER INELIGIBLE ON DATES OF SERVICE	184 (01/15/13)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.	1396	PRESCRIBING PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N269 (01/01/14)	Missing/incomplete/invalid other provider name.	0218	REFERRING/OTHER PHYSICIAN PROVIDER NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (01/01/14)	Missing/incomplete/invalid other provider primary identifier.	0006	INVALID REFERRING/OTHER PROVIDER IDENTIFIER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	1231	NPI IS MISSING FOR OTHER PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	1232	NPI IS INVALID FOR OTHER PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.	1271	OTHER NPI SAME AS BILLING/SERVICING NPI	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.	1264	NPI NOT CROSSWALKED - OTHER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.	1265	PROVIDER NOT MATCHED - OTHER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N276 (11/01/15)	Missing/incomplete/invalid other payer referring provider identifier.	0639	REFERRING PROVIDER MUST BE NURSING FACILITY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N279 (11/01/15)	Missing/incomplete/invalid pay-to provider name.	1628	REQUIRED DENTAL CLAIM NOT RECEIVED FOR SAME DOS	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N285 (11/01/15)	Missing/incomplete/invalid referring provider name.	0275	RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	0231	REFERRING PROVIDER NUMBER REQUIRED - GSHP	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	0262	REFER/OTHER PHY REQ FOR CONSULT AND/OR 2ND OPINION	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	0277	REFERRING PROVIDER NUMBER REQUIRED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	0331	SECOND OPINION REQUIRED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	0333	INVALID/MISSING SECOND OPINION INDICATOR	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	0339	DENY SECOND OPINION NOT OBTAINED	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.	1226	NPI IS INVALID FOR REFERRING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (07/01/08)	Missing/incomplete/invalid referring provider primary identifier.	1270	REFERRING NPI SAME AS BILLING/SERVICING NPI	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.	1410	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - REFERRING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.	1420	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - REFERRING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.	1246	NPI NOT CROSSWALKED - UB04 REFERRING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.	1247	PROVIDER NOT MATCHED - REFERRING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.	1263	PROVIDER ID AND NPI REQUIRED - REFERRING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.	1397	REFERRING PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	1219	TAXONOMY CODE IS MISSING FOR SERVICING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	1220	TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	1221	NPI IS MISSING FOR SERVICE/RENDERING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	1222	NPI IS INVALID FOR SERVICE/RENDERING PROVIDER	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/09/11)	Missing/incomplete/invalid rendering provider primary identifier.	1306	NPI IS INVALID FOR SUPERVISING PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.	1405	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SERVICING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.	1418	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SERVICING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	1236	ZIP CODE IS MISSING OR INVALID	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	1237	NPI NOT CROSSWALKED - SERV/REND	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	1238	PROVIDER NOT MATCHED - SERV/REND	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N291 (01/01/13)	Missing/incomplete/invalid rendering provider secondary identifier.	1245	PROVIDER ID AND NPI REQUIRED - SERVICING	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.	1297	BILLING ZIP CODE IS MISSING OR INVALID	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.	1307	NPI NOT CROSSWALKED - SUPERVISING PROVIDER	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (07/14/14)	Missing/incomplete/invalid rendering provider secondary identifier.	1427	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SUPERVISING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N297 (11/01/15)	Missing/incomplete/invalid supervising provider primary identifier.	1305	INVALID SUPERVISING MEDICAID PROVIDER ID.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N297 (07/14/14)	Missing/incomplete/invalid supervising provider primary identifier.	1414	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SUPERVISING	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.	1394	SUPERVISING PROVIDER INELIGIBLE ON DATES OF SERVICE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.	1402	SUPERVISING PROVIDER NOT FOUND ON PROVIDER DATABASE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).	0014	STATEMENT THRU DATE < OCCURRENCE DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).	0189	EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N300 (01/01/14)	Missing/incomplete/invalid occurrence span date(s).	0069	INVALID OCCURENCE DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	0364	CLAIM SPANS HMO ENROLLMENT - CALL REVS	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	1285	INVALID UB04 OCCURRENCE SPAN FROM DATE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	1287	STATEMENT THRU DATE < UB04 OCCUR SPAN THRU DATE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N301 (11/01/15)	Missing/incomplete/invalid procedure date(s).	0135	INV/MISS CURRENT EXAM DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N302 (11/01/15)	Missing/incomplete/invalid other procedure date(s).	1650	MISSING QUALIFYING OTHER PROCEDURE ON DAY OF SERVICE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N304 (11/01/15)	Missing/incomplete/invalid dispensed date.	0137	CURRENT EXAM GREATER THAN DATE DISPENSED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N306 (11/01/15)	Missing/incomplete/invalid acute manifestation date.	0499	ACUTE DAYS BILLED EQUAL ZERO	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.	0183	MEDICARE PAYMENT DATE IS MISSING OR INVALID	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.	1379	PMT AMT ON THE APPROVED HMS ADJ GT THAN OR EQUAL TO ORIG PMT	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N318 (01/01/14)	Missing/incomplete/invalid discharge or end of care date.	0018	SERVICE THRU DATE < SERVICE FROM DATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	0013	INVALID BIRTHDATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (11/01/15)	Missing/incomplete/invalid patient birth date.	0311	CORRECT D.O.B. OR RESUBMIT CLAIM UNDER BABY'S NUMBER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	1809	CLAIM CHECK: DOB CANNOT BE GREATER THAN DATE OF SERVICE	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	1821	CLAIM CHECK: BIRTH DATE IS A FUTURE DATE	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N329 (12/12/07)	Missing/incomplete/invalid patient birth date.	1824	CLAIM CHECK: AGE CANNOT BE GREATER THAN 124 YEARS	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	1849	CLAIM CHECK: INVALID DATE OF BIRTH CENTURY VALUE	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	1850	CLAIM CHECK: INVALID DATE OF BIRTH	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	0383	DATE OF SERVICE LATER THAN DATE OF DEATH	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	0384	DATE OF SERVICE LATER THAN DATE OF DEATH	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N330 (01/01/16)	Missing/incomplete/invalid patient death date.	1440	PROCEDURE NEEDS A DATE OF DEATH TO BE PROCESSED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	1643	CLAIM VOID PENDED - UNCONFIRMED RECIPIENT DEATH	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	1644	CLAIM VOIDED - RECIPIENT DEATH	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N341 (01/01/14)	Missing/incomplete/invalid surgery date.	0049	INV/MISS SURG DATE - SUPPLY VALID DATE OR REMOVE PROC CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N345 (06/18/07)	Date range not valid with units submitted.	1819	CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N345 (06/18/07)	Date range not valid with units submitted.	1823	CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	0324	HMO COVERED SERVICE - PAYMENT NOT JUSTIFIED BY ATTACHMENT	B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	0876	CO-PAY FOR SERVICE DATE PAID - SEE CONFLICTING ICN ON RA	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
N350 (11/01/15)	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	0669	DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED	252 (11/01/15)	An attachment/other documentation 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).
N351 (01/01/14)	Service date outside of the approved treatment plan service dates.	0782	GSHP DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
N354 (11/01/15)	Incomplete/invalid invoice.	0640	INVOICE/PRICE LIST ATTACHED IS INVALID/INSUFFICIENT	251 (11/01/15)	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).
N357 (03/01/20)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	1682	TELEDENTISTRY CODE REQUIRES RELATED SERVICE CODE	B15 (03/01/20)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N357 (01/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	1686	SUD MGMT CLAIM WITH NO MATCHING E&M CLAIM	B15 (01/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N357 (12/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	1687	GROUP CLINICAL VISIT CLAIM WITH NO MATCHING E&M CLAIM	B15 (12/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	1703	POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D	272 (01/01/21)	Coverage/program guidelines were not met.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0148	RESPIRE CARE EXCEEDS MAXIMUM OF 5 DAYS	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0276	UTILIZATION EXCEEDS ESTABLISHED PARAMETERS	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	0403	DURATION AT THIS DOSAGE EXCEEDED	119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0672	SPLIT CLAIM RECIP ELIG ON DISCHARGE DATE ONLY-NO PMT DUE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0673	SPLIT CLAIM ALL ELIG DAYS ARE RESIDENTIAL-NO PAYMENT DUE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0674	SPLIT CLAIM SNF/ICF DAYS AT/BELOW DRG HIGH TRIM-NO PMT DUE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0675	SPLIT CLAIM NJ HIV OUTLIER CLAIM-SNF/ICF DAYS NOT PAYABLE	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	0699	LIFETIME RESERVE DAYS EXCEED MEDICARE MAXIMUM OF 60 DAYS	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0705	CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0706	30 DAY NEONATAL CARE LIMIT	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0707	60 DAY NEONATAL CARE LIMITATION	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0712	CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM-DENY	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	0720	TARGETED CASE MANAGEMENT LIMIT EXCEEDED	119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	0733	CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	0837	TBI BEHAVIOR PROGRAM EXCEEDS UNITS OF SERVICE	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	0859	CLAIM OVERLAPS CALENDAR WORK WEEK-SUN.12:00AM TO SAT.11:59PM	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	0910	PAYMENT EXCEEDS THRESHOLD	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	0936	INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	1012	VALUE OF ONE OR MORE OF THESE FIELDS WAS > MAX ALLOWED	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/29/16)	The number of Days or Units of Service exceeds our acceptable maximum.	1606	RATE DECREASE WHEN PARTIAL HOSPITALIZATION EXCEEDS 24 MONTH	119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	1623	OUTPATIENT ACUTE ADULT PARTIAL HOSPITALIZATION TIME EXCEEDED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (06/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	1649	OP TRANS PMT REDUCED BY PREVIOUS PAID OP TRANS CLM	119 (06/01/14)	Benefit maximum for this time period or occurrence has been reached.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N362 (01/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	1651	MAX UNITS REACHED FOR 2 CONSECUTIVE DAY OCCURRENCE	222 (01/01/15)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	1652	MENTAL HEALTH CLAIM CUTBACK - BENEFIT LIMIT REACHED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	1670	NUMBER OF UNITS EXCEEDS 6 IN A 14 DAY PERIOD	96 (09/01/20)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (01/01/16)	The number of Days or Units of Service exceeds our acceptable maximum.	1805	CLAIM CHECK: CLAIM LINES EXCEED MAXIMUM	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
N375 (11/01/15)	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	0386	KID-CARE UNABLE TO DETERMINE COVERAGE	252 (11/01/15)	An attachment/other documentation 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).
N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.	0128	CLAIM > \$400-RESUB CLAIM VERIFYING METRIC QUANTITY REPORTED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.	1330	METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N378 (05/02/11)	Missing/incomplete/invalid prescription quantity.	1349	VERIFY METRIC QUANTITY REPORTED	226 (05/02/11)	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.)
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0203	PROVIDER ON REVIEW - STATE PEND	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0222	LTC AGREEMENT TERMINATED:DISCHARGE PENDING FINAL DAY	27 (11/01/15)	Expenses incurred after coverage terminated.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0243	PROVIDER NOT AUTHORIZED-TARGETED CASE MANAGEMENT	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0281	POS VOID TRANSACTION FOR PROVIDER-ON-REVIEW	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0282	POS PROVIDER ON REVIEW-NO Z NO OVERRIDE	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0691	PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVIC	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0736	LAB SERVICE	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0762	MENTAL HEALTH SERVICES EXCEED \$900	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N381 (01/29/16)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	0990	DELAYED PAYMENT OF PROPRIETARY ELECTRONIC CLAIM	119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	1207	PAYMENT PENDING SFY JULY 1 APPROPRIATION	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	1210	PART A EXHAUSTED CHARGES IS GREATER THAN 99,999.99	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	1363	CANNOT CHANGE A DOCUMENT LEVEL SURGERY	A1 (02/13/12)	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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	1364	CANNOT ADJUST A LINE LEVEL SURGERY	A1 (11/15/11)	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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N382 (02/01/19)	Missing/incomplete/invalid patient identifier.	0011	RECIPIENT NUMBER MISSING OR INVALID	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (11/01/15)	Missing/incomplete/invalid patient identifier.	0100	ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N382 (01/01/16)	Missing/incomplete/invalid patient identifier.	0306	MEDICAID RECIP ID CORRECTED	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (11/01/15)	Missing/incomplete/invalid patient identifier.	0321	RECIPIENT NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N383 (01/01/14)	Not covered when deemed cosmetic.	1804	CLAIM CHECK: COSMETIC PROCEDURE	50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N383 (01/01/14)	Not covered when deemed cosmetic.	1807	CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED	50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N388 (11/01/15)	Missing/incomplete/invalid prescription number.	0131	INV/MISS PRESCRIPTION NUMBER	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N388 (09/01/20)	Missing/incomplete/invalid prescription number.	2169	RX IS NOT ON FILE OR INCOMPLETE	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N391 (11/01/15)	Missing emergency department records.	0878	NO EMERGENCY CLAIM FOR ALIEN TRANSPORTATION CLAIM	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N398 (11/01/15)	Missing elective consent form.	0354	HYSTERECTOMY REQUIRES ATTACHMENT	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	0033	SUBMITTER ID IS NOT NUMERIC OR = "O".	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	0227	PROVIDER NOT APPROVED FOR EMC	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	0271	SUBMITTER NOT APPROVED FOR PROVIDER.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	0437	INVALID SUBMITTED ID	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N408 (11/01/15)	This payer does not cover deductibles assessed by a previous payer.	0455	RECIPIENT NOT ELIGIBLE ON FROM D.O.S. NO DEDUCTIBLE DUE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N408 (02/01/16)	This payer does not cover deductibles assessed by a previous payer.	1388	MEDICARE HMO DEDUCTIBLE EXCEEDS YEARLY MAXIMUM	96 (02/01/16)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N418 (11/01/15)	Misrouted claim. See the payer's claim submission instructions.	0400	NOT VALID CAPITATION CLAIM	109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N429 (01/01/14)	Not covered when considered routine.	0752	VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM	49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N430 (11/01/15)	Procedure code is inconsistent with the units billed.	0149	CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (01/29/16)	Alert: Adjustment based on a Recovery Audit.	0964	ADJUSTMENT OR VOID CORRESPONDS TO CANCELLED MMIS CHECK	97 (01/29/16)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	1348	HMS AUDIT - ADJUSTMENT/VOID REQUEST DENIED	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	1373	HMS MEDICARE RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	1374	HMS MEDICARE RECOVERY - PROVIDER ADJUSTMENTS ALLOWED	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	1376	HMS RAC RECOVERY - NO FURTHER PROVIDER ADJUSTMENTS	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	1377	HMS RAC RECOVERY PROVIDER ADJUSTMENTS ALLOWED	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N434 (12/09/13)	Missing/Incomplete/Invalid Present on Admission indicator.	1312	MISSING OR INVALID PRESENT ON ADMISSION INDICATOR.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N434 (11/01/15)	Missing/Incomplete/Invalid Present on Admission indicator.	1320	POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE.	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	0731	THREE YEAR XRAY LIMITATION EXCEEDED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	0857	WEEKLY PERSONAL CARE ASSISTANCE/MENTAL HEALTH HRS EXCEED 25	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	0858	WEEKLY PERSONAL CARE ASSISTANT (PCA) SVCS HOURS EXCEED 40	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N435 (01/01/21)	Exceeds number/frequency approved /allowed within time period without support documentation.	1702	DOULA VISITS EXCEED LIMIT	119 (01/01/21)	Benefit maximum for this time period or occurrence has been reached.
N440 (11/01/15)	Incomplete/invalid anesthesia physical status report/indicators.	0160	INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N443 (01/01/14)	Missing/incomplete/invalid total time or begin/end time.	0314	CLAIM SERV. DATES OVERLAP SPEC. PROG. ELIG. BEGIN/END DATES.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N445 (11/01/15)	Missing document for actual cost or paid amount.	0239	ALTERED DOCUMENTATION-ORIGINAL PRICE LIST/INVOICE NEEDED	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N446 (11/01/15)	Incomplete/invalid document for actual cost or paid amount.	0105	FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15	251 (11/01/15)	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).
N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	0573	CAPITATION RATE NOT ON FILE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	1216	DRUG REBATE INDICATOR ZERO OR NO MCAID/GA REBATE AGREEMENT	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N463 (11/01/15)	Missing support data for claim.	0366	MISSING/INVALID STERILIZATION TIME REASON	250 (11/01/15)	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).



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	0648	INVALID NEW YORK EXEMPT UNIT RATE CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	0649	MISSING NEW YORK EXEMPT UNIT RATE DATA	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	0659	NF RATE NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	0671	MEDICARE RATE NOT ON FILE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	0199	SUBMIT HARD COPY CLAIM AND MEDICARE EOB	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	0511	OVERRIDE-USE PROVIDER MEDICARE PER DIEM RATE.	22 (11/01/15)	This care may be covered by another payer per coordination of benefits.



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N479 (01/01/16)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	0845	ADJUSTMENT DENIED/ EOMB REQUIRED	P21 (01/01/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1621	DENY REASON CODE OR DENY EXPLANATION MISSING ON EOB	P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.
N480 (01/29/16)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	0984	CLAIM REQUIRES REVIEW - MEDICARE PART B ATTACHMENT	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N480 (11/01/15)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	0988	NEGATIVE MEDICARE EOB, REBILL AS ZERO PRIOR PAY	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N517 (01/01/14)	Resubmit a new claim with the requested information.	0293	DIAGNOSIS NOT ALLOWED FOR SEX	10 (01/01/14)	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N517 (01/01/14)	Resubmit a new claim with the requested information.	0411	GSHP PRIOR AUTHORIZATION NOT REQUIRED..	15 (01/01/14)	The authorization number is missing, invalid, or does not apply to the billed services or provider.
N517 (01/01/14)	Resubmit a new claim with the requested information.	0479	PRIV PSYCH HOSP - LTC-PAT AGE > 21 AND < 65	9 (01/01/14)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N517 (01/01/16)	Resubmit a new claim with the requested information.	0597	VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE	181 (01/01/16)	Procedure code was invalid on the date of service.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	0162	INV/MISS PROCEDURE CODE MODIFIER	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	0256	PROCEDURE MODIFIER REQUIRED	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	0267	PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	0519	MODIFIER ADDED - TRIP OVER 15 MILES	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	0860	PROCEDURE CODE MODIFIERS IN CONFLICT	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	1834	CLAIM CHECK: INVALID MODIFIER	4 (06/18/07)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0695	ADJUSTMENT / VOID ALREADY IN PROCESS	18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)



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N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0800	EXACT DUPLICATE BILL	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0801	POSSIBLE DUPLICATE CONFLICT	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0802	PHYSICIAN AND EPSDT DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0803	INPATIENT AND LTC DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0804	INPATIENT AND OUTPATIENT DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0807	INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0809	POSSIBLE DUPLICATE	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0810	DUPLICATE BILL - OVERLAPPING DATES OF SERVICES	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0812	TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0813	OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0814	PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0815	AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0816	CLINIC AND CLINIC CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)



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N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0817	P&O AND P&O CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0818	DME AND DME CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0819	LAB AND LAB CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0820	OPTOMETRIST AND OPTOMETRIST CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0821	MID-LEVEL PRACT AND CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0822	EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0823	LTC AND LTC CROSSOVER DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	0865	LTC AND HOSPICE DUPLICATE ERROR	18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1201	MULTIPLE HIST RECS FOUND FOR ADJ/VOID	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1607	FQHC DUPLICATE CONFLICT	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1622	CHARITY AND MEDICAID DUPLICATE ERROR	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1631	THERAPY CONFLICT WITH RESIDENTIAL, PARTIAL CARE, TRANSPORT	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1641	HOSPICE TRANSFER WITH MORE THAN ONE OVERLAPPING SERVICE DAY	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)



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N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1642	HOSPICE XFER DAY OF DISCHARGE WITH > 1 OVERLAPPING SVC DAY	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (05/04/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1673	DEPT. OF CORRECTIONS/MEDICAID DUPLICATE ERROR	18 (05/04/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1812	CLAIM CHECK: PROCEDURE CODE IS MISSING	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	1813	CLAIM CHECK: DATE OF SERVICE REQUIRED FOR PROCEDURE	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N531 (01/01/14)	Not qualified for recovery based on direct payment of premium.	0773	DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE(S)	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
N538 (11/01/15)	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	0645	MISSING NEW YORK EXEMPT FACILITY RATE DATE	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N554 (11/01/15)	Missing/Incomplete/Invalid Family Planning Indicator.	0147	FAMILY PLANNING INDICATOR MUST BE Y OR N	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N567 (05/01/16)	Not covered when considered preventative.	1340	PROVIDER PREVENTABLE CONDITION - NOT COVERED	233 (01/01/14)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
N569 (12/01/22)	Not covered when performed for the reported diagnosis.	1860	CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE	A1 (12/01/22)	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.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	0201	SERVICING PROVIDER NOT ELIGIBLE ON DATE(S) OF SERVICE	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	0210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	0387	BILLING PROVIDER NOT ENROLLED IN CLIA	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	0388	BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (11/01/15)	Missing/incomplete/invalid credentialing data.	0389	BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (11/01/15)	Missing/incomplete/invalid credentialing data.	0650	MISSING PENNSYLVANNIA HOSPITAL FISCAL YEAR DATA	251 (11/01/15)	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).
N572 (01/01/14)	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	1204	ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	1325	INVALID PROVIDER TYPE FOR REFERRING PROVIDER	183 (04/02/10)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	1336	INVALID REFERRING PROVIDER FOR PLACE OF SERVICE 2 OR 4	183 (01/23/12)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	1382	INVALID PROVIDER TYPE - PRESCRIBING PHYSICIAN	184 (11/01/15)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	0026	CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING LIMITS	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	0027	INPATIENT CLAIM W/O ATTACHMENT EXCEEDS TIMELY FILING LIMITS	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	0029	MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	0076	CLAIM W/ATTACH EXCEEDS TIMELY FILING	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	0077	I/P CLAIM EXCEEDS TIMELY FILING LIMIT	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N587 (11/01/15)	Policy benefits have been exhausted.	0717	PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N587 (01/01/14)	Policy benefits have been exhausted.	0875	FISCAL YEAR FUNDS EXHAUSTED	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N587 (04/01/18)	Policy benefits have been exhausted.	1014	DDD SELF DIRECTED INSUFFICIENT PA FUNDING TO FULFILL CLAIM	119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.
N587 (04/02/18)	Policy benefits have been exhausted.	1015	DDD/IME CLAIM MODIFIERS DO NOT MATCH PA MODIFIERS	119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	1255	MEDICARE SUP CLAIM W/O EXHAUSTED DATE OR CHARGES	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	1256	MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	1257	MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.



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N587 (11/01/15)	Policy benefits have been exhausted.	1627	EXHAUSTED CHARGES A3 AMOUNT REPORTED ON THE CLAIM	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N622 (01/01/14)	Not covered based on the date of injury/accident.	0021	BILLED DATE LESS THAN THRU DATE	110 (01/01/14)	Billing date predates service date.
N622 (01/01/14)	Not covered based on the date of injury/accident.	0023	BILLED DATE < STATEMENT THRU DATE	110 (01/01/14)	Billing date predates service date.
N622 (11/01/15)	Not covered based on the date of injury/accident.	0424	ELIG ENDED BEFORE CLAIM THRU DATE FOR DME-CUTBACK APPLIED	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N622 (01/01/14)	Not covered based on the date of injury/accident.	0490	INPATIENT DATE OF SURGERY < SERVICE FROM DATE	110 (01/01/14)	Billing date predates service date.
N622 (01/01/14)	Not covered based on the date of injury/accident.	0529	CLAIM DATES OF SERVICE BEFORE INITIAL ASSESSMENT DATE	110 (01/01/14)	Billing date predates service date.
N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	0722	SERVICE/VISIT CONFLICT	231 (11/01/15)	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	1655	SERVICE/VISIT CONFLICT	234 (11/01/15)	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.)
N629 (11/28/16)	Reviews/documentation/notes/summaries/reports/charts not requested.	1448	SERVICE NOT RELATED TO TERMINAL COND FOR HOSPICE BENEFICIARY	95 (11/28/16)	Plan procedures not followed.
N630 (11/01/15)	Referral not authorized by attending physician.	1391	REFERRING PROVIDER INELIGIBLE ON DATES OF SERVICE	183 (01/15/13)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N633 (01/01/14)	Additional anesthesia time units are not allowed.	0759	PAYMENT REDUCED - SURGERY/ANESTHESIA CONFLICT	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N637 (01/01/14)	Consultations are not allowed once treatment has been rendered by the same provider.	0745	HOSPITAL CALL/CONSULTATION CONFLICT	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0734	SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0740	OPT APP EXCEEDS PROGRAM LIMITATION	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0747	PROPHYLAXIS LIMIT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0748	ORAL EXAMINATION LIMIT	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0768	EXCESSIVE PRIVATE DUTY NURSING HOURS-PA REQUIRED	222 (01/01/14)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	0872	FAMILYCARE THERAPY SERVICE LIMITS	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
N640 (11/01/15)	Exceeds number/frequency approved/allowed within time period.	1008	CARRIER AMOUNT EXCEEDS MAXIMUM VALUE ALLOWED	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N640 (01/01/16)	Exceeds number/frequency approved/allowed within time period.	1858	CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).	0881	URO/DRG AUDIT ADJUST - REQUEST DENIED	167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N647 (01/01/14)	Adjusted based on diagnosis-related group (DRG).	0924	DISCHARGE DATE AND READMIT DATE WITHIN SET TIME SPANS FOR NY	167 (01/01/14)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).	1401	PAYMENT ADJUSTED FOR HOSPITAL ACQUIRED CONDITION	233 (12/09/13)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N652 (11/01/15)	The date of service is before the date of loss.	0110	DATE OF SERVICE < ADMISSION DATE	26 (11/01/15)	Expenses incurred prior to coverage.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0058	INV/MISS PROCEDURE CODE/REVENUE CODE/CHARGE	199 (11/01/15)	Revenue code and Procedure code do not match.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0066	INVALID SPECIAL PROGRAM INDICATOR	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0081	INV/MISS CLINIC CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0082	EMERG ROOM REV CODE (S) PRESENT - CLINIC CODE '00' MISSING	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0083	REV CODE 099,36X,37X,49X OR 71X REQ VALID SURGICAL PROC	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0138	ACCIDENT INDICATOR MUST BE Y, N, OR SPACE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0139	EPSDT INDICATOR NOT Y, N OR SPACE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0142	INV/MISS ORIGIN CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0143	INV/MISS DESTINATION CODE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0235	INVALID DIVISION OF JUVENILE SERVICES CLAIM.	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0241	22 MOD SERVICES NOT JUSTIFIED/PAID AT UNMODIFIED RATE	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0251	PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS	251 (11/01/15)	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).
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0253	REVENUE/PROCEDURE NOT VALID ON DATE(S) OF SERVICE	181 (11/01/15)	Procedure code was invalid on the date of service.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0480	GROUPER ASSIGNED A NEW DRG CODE	A8 (11/01/15)	Ungroupable DRG.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0665	PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST	199 (11/01/15)	Revenue code and Procedure code do not match.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	0725	BIOPSY D&C CONFLICT	236 (11/01/15)	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.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	1303	MENTAL HEALTH SERVICE UNDER 2 NOT COVERED	9 (05/21/12)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	1328	BILL OUTPATIENT DRUG CLAIMS USING REVENUE CODES 631 THRU 637	199 (03/29/10)	Revenue code and Procedure code do not match.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	1378	FQHC MENTAL HEALTH/MEDICAL PROC/DIAG MISMATCH	11 (11/01/15)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (01/01/16)	This should be billed with the appropriate code for these services.	1441	RECIP OUTSIDE 60 DAYS NOT ELIGIBLE FOR HIGHER HOSPICE RATE	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	1660	PSYCHOTHERAPY ADD-ON CODE WITH NO APPROP E&M CODE IN HISTORY	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (09/01/20)	This should be billed with the appropriate code for these services.	2170	ACQUISITION INVOICE DOES NOT SUPPORT NDC BILLED	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (09/01/20)	This should be billed with the appropriate code for these services.	2183	EXCEEDED REFILLS ALLOWED	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N661 (08/02/20)	Documentation does not support that the services rendered were medically necessary.	1426	EARLY ELECTIVE DELIVERY	50 (08/01/20)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.	1469	EARLY ELECTIVE DELIVERY DENIAL OVERRIDDEN	50 (01/01/21)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N663 (01/01/15)	Adjusted based on an agreed amount.	1347	MLTSS WAIVER FFS CLAIM REPROCESS.	166 (01/01/15)	These services were submitted after this payers responsibility for processing claims under this plan ended.
N666 (01/01/14)	Only one evaluation and management code at this service level is covered during the course of care.	0735	INITIAL VISIT/ANNUAL EXAM/EPSTD EXAM LIMIT	96 (01/01/14)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N667 (11/01/15)	Missing prescription.	0641	RX FROM PHYSICIAN REQUIRED	250 (11/01/15)	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).
N668 (09/01/20)	Incomplete/invalid prescription.	2153	RX INCORRECTLY SUBMITTED AS A COMPOUND	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	2154	INITIAL CONTROLLED DRUG FILLED > 30 DAYS PAST DATE WRITTEN	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	2156	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCRBR NPI	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	2159	RX INCOMPLETE-MISSING/INCOMP/AMBIG PRESRBRS AUTH AGENT	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N668 (09/01/20)	Incomplete/invalid prescription.	2162	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCR INFO	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	2166	INCORRECT COMPOUND INGREDIENT NDC# SUBMITTED	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	2175	NO NAME ON RX	175 (09/01/20)	Prescription is incomplete.
N669 (05/01/16)	Adjusted based on the Medicare fee schedule.	0623	MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE	23 (01/01/14)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	0901	MULTIPLE SURGERY-PAID AS PRIMARY PROCEDURE	59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	0902	MULTIPLE SURGERY-PAID AS SECONDARY PROC, MAX 200% OF PRIMARY	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	0903	MULT SURG - PRIME PROC FEE REDUCED BY PRIOR PAID CLAIM	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (11/01/15)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	0904	MULTIPLE SURGERY-\$0 PAID, LIMIT EXCEEDED	59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	0907	MULT SURG- 1ST UNIT PRIMARY, ADDT'L AS SECONDARY - 200% MAX	59 (10/16/03)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.	1463	PENDING DOULA INCENTIVE PAYMENT FOR REPROCESS	B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.	1704	DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS	B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	1322	SERVICE/PROCEDURE INCLUDED IN COMPOSITE RATE	234 (11/01/15)	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.)
N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	1337	ASC PROCEDURE SERVICE	96 (11/01/15)	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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	0452	CERTIFICATION OF EMERGENCY FORM MISSING/INVALID	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	0453	PA/CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	0909	REQUIRES MATCHING EPSDT CLAIM FOR PAYMENT	250 (11/01/15)	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).
N702 (01/29/16)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	0825	INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N702 (11/01/15)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	0899	DUPLICATE ICN	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N702 (12/04/17)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1676	DAILY/WEEKLY PSYCHOTHERAPY SERVICE LIMITS EXCEEDED	18 (12/04/17)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N702 (07/01/20)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1688	CLM FOR REQUIRED BASE TIME CODE NOT RECEIVED FOR ADD ON CODE	129 (07/01/20)	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.)
N702 (01/01/21)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	1752	NO PRESUMPTIVE DRUG TEST WITHIN 7 DAYS	129 (01/01/21)	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.)
N705 (05/01/16)	Incomplete/invalid documentation.	0838	PROVIDER-PRODUCED EOB INCOMPLETE	251 (01/01/14)	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).
N705 (12/07/20)	Incomplete/invalid documentation.	1459	PRA INVALID- NO RECIPIENT FOUND FOR PRENATAL SERVICE	226 (12/07/20)	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.)



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
Sequenced by HIPAA Remark Code
Last Date Loaded - 4/22/2024

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N705 (08/17/21)	Incomplete/invalid documentation.	1464	PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE	226 (08/17/21)	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.)
N705 (08/17/21)	Incomplete/invalid documentation.	1465	PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS	226 (08/17/21)	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.)
N706 (11/01/15)	Missing documentation.	0349	SEC OPINION FORM INCOMPLETE,MISSING DATA OR IS OUT OF DATE	252 (11/01/15)	An attachment/other documentation 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).
N706 (11/01/15)	Missing documentation.	0352	INSUFFICIENT MEDICAL DOCUMENTATION FOR STERILIZATION	252 (11/01/15)	An attachment/other documentation 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).
N706 (11/01/15)	Missing documentation.	0355	STERILIZATION FORM REQUIRED	252 (11/01/15)	An attachment/other documentation 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).
N706 (11/01/15)	Missing documentation.	0464	HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED	252 (11/01/15)	An attachment/other documentation 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).
N706 (01/01/16)	Missing documentation.	0842	ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED	163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.
N822 (12/01/22)	Missing procedure modifier(s).	1856	CLAIMSXTEN: MISSING MODIFIER 26	4 (12/01/22)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N883 (01/15/24)	Alert: Processed according to state law	1473	TPL EDITING BYPASSED - PAY AND CHASE CLAIM	22 (01/15/24)	This care may be covered by another payer per coordination of benefits.



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N950 (07/12/21)		0546	PAAD/SR GOLD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER	184 (01/01/14)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.