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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
		2173	**INCORRECT PRESCRIBER DEA#/NPI# SUBMITTED**		
3 (10/16/03)	Co-payment Amount	**0941**	**SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM**	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.
3 (04/01/18)	Co-payment Amount	**1625**	**COMMERCIAL HMO CO-PAY/COINS/DEDUCT**	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.
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.	**0162**	**INV/MISS PROCEDURE CODE MODIFIER**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
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.	**0163**	**PROCEDURE - SPANNING DATES OF SERVICE**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
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.	**0168**	**MISSING MANDATORY PROCEDURE CODE MODIFIER**	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.
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.	**0169**	**INVALID MODIFIER FOR PROC CODE,CLM TYPE OR SERVICE DATE**	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.
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.	**0232**	**'YD' OR 'UD' MODIFIER NOT ALLOWED**	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.
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.	**0241**	**22 MOD SERVICES NOT JUSTIFIED/PAID AT UNMODIFIED RATE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.

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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.	**0256**	**PROCEDURE MODIFIER REQUIRED**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
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.	**0267**	**PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
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.	**0519**	**MODIFIER ADDED - TRIP OVER 15 MILES**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
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.	**0584**	**MODIFIER REMOVED - TRIP LESS THAN 16 MILES**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
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.	**0589**	**MODIFIER NOT ALLOWED**	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.
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.	**0860**	**PROCEDURE CODE MODIFIERS IN CONFLICT**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
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.	**1204**	**ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ**	N572 (01/01/14)	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
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.	**1834**	**CLAIM CHECK: INVALID MODIFIER**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.

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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.	**1856**	**CLAIMSXTEN: MISSING MODIFIER 26**	N822 (12/01/22)	Missing procedure modifier(s).
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.	**2231**	**BENEFIT STAGE AMOUNT IS NOT NUMERIC**		
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.	**1314**	**HOSPICE PROCEDURE/PLACE OF SERVICE RESTRICTION**	M77 (11/01/15)	Missing/incomplete/invalid/inappropriate place of service.
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.	**0254**	**PROCEDURE CODE NDC AGE RESTRICTED**	N129 (11/01/15)	Not eligible due to the patient's age.
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.	**0351**	**RECIP AGE AT THE TIME OF STERILIZATION CONSENT DTE < 21**	N129 (11/01/15)	Not eligible due to the patient's age.
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.	**1705**	**DOULA VISIT EXCEEDS AGE LIMIT**	N129 (01/01/21)	Not eligible due to the patient's age.
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.	**1824**	**CLAIM CHECK: AGE CANNOT BE GREATER THAN 124 YEARS**	N329 (12/12/07)	Missing/incomplete/invalid patient birth date.
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.	**1825**	**CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT**	N129 (01/01/14)	Not eligible due to the patient's age.

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Last Date Loaded - 4/20/2025

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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.	**1826**	**CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT**	N129 (01/01/14)	Not eligible due to the patient's age.
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.	**1827**	**CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT**	N129 (01/01/14)	Not eligible due to the patient's age.
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.	**1828**	**CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT**	N129 (01/01/14)	Not eligible due to the patient's age.
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.	**1881**	**CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED**	N129 (01/01/14)	Not eligible due to the patient's age.
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.	**1803**	**CLAIM CHECK: INVALID OR MISSING GENDER**	MA39 (06/18/07)	Missing/incomplete/invalid gender.
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.	**1831**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE**	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.
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.	**1893**	**CLAIM CHECK: PROCEDURE GENDER RESTRICTION**	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.
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.	**0125**	**THIS PROVIDER INVALID WITH MODIFIER UE OR U6 OR WI OR WR**	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.

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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.	**0202**	**PROVIDER CANNOT SUBMIT THIS CLAIM TYPE**	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
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.	**0237**	**PROCEDURE/PROVIDER SPECIALTY RESTRICTION**	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
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.	**0278**	**PROVIDER NOT AUTHORIZED THIS PROCEDURE**	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
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.	**0380**	**CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)**	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
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.	**0381**	**CLAIM SUBMITTED FFS-UNABLE TO DETERMINE IN-PLAN/OUT-OF-PLAN**	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
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.	**0590**	**PROC CODE BILLED IS ONLY PAYABLE TO A SPECIALIST**	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
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.	**0479**	**PRIV PSYCH HOSP - LTC-PAT AGE > 21 AND < 65**	N517 (01/01/14)	Resubmit a new claim with the requested information.
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.	**1303**	**MENTAL HEALTH SERVICE UNDER 2 NOT COVERED**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0293**	**DIAGNOSIS NOT ALLOWED FOR SEX**	N517 (01/01/14)	Resubmit a new claim with the requested information.

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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.	**2112**	**CONFLICTING GENDER CODE - CONFIRM GENDER AND BENE ID NUMBER**		
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.	**0923**	**DAILY DOSAGE LESS THAN MINIMUN RECOMMENDED DOSAGE**	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.
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.	**1378**	**FQHC MENTAL HEALTH/MEDICAL PROC/DIAG MISMATCH**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**2227**	**DIAGNOSIS CODE QUALIFIER VALUES ARE NOT EQUAL**		
14 (10/16/03)	The date of birth follows the date of service.	**0401**	**DATE OF SERVICE < DATE OF BIRTH**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
14 (01/01/16)	The date of birth follows the date of service.	**2113**	**CONFLICTING DATE OF BIRTH - CONFIRM DOB AND BENE ID NUMBER**		
15 (01/01/14)	The authorization number is missing, invalid, or does not apply to the billed services or provider.	**0411**	**GSHP PRIOR AUTHORIZATION NOT REQUIRED..**	N517 (01/01/14)	Resubmit a new claim with the requested information.
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.	**0001**	**GENERIC ELIGIBILITY RECORD USED.**	MA43 (11/01/15)	Missing/incomplete/invalid patient status.
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.	**0002**	**BILLING PROVIDER NUMBER MISSING/INVALID**	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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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.	**0004**	**INV/MISS PRESCRIBER'S MEDICAID ID NUMBER**	N31 (01/01/14)	Missing/incomplete/invalid prescribing provider identifier.
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.	**0005**	**INV/MISS ATTENDING PHYSICIAN MEDICAID ID NUMBER**	N253 (01/15/13)	Missing/incomplete/invalid attending provider primary 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.	**0006**	**INVALID REFERRING/OTHER PROVIDER IDENTIFIER**	N270 (01/01/14)	Missing/incomplete/invalid other provider primary 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.	**0007**	**BILLING PROVIDER CHECK DIGIT INVALID**	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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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.	**0010**	**INVALID SERVICING PROVIDER MEDICAID ID NUMBER**	MA134 (11/01/15)	Missing/incomplete/invalid provider number of the facility where the patient resides.
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.	**0011**	**RECIPIENT NUMBER MISSING OR INVALID**	N382 (02/01/19)	Missing/incomplete/invalid patient identifier.
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.	**0012**	**MISSING RECIPIENT NAME**	MA36 (10/16/03)	Missing/incomplete/invalid patient name.
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.	**0013**	**INVALID BIRTHDATE**	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.

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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.	**0015**	**STATEMENT THRU DATE < STATEMENT FROM DATE**	M59 (11/01/15)	Missing/incomplete/invalid 'to' date(s) 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.	**0016**	**INV/MISS SERVICE FROM DATE**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) 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.	**0017**	**INV/MISS SERVICE THRU DATE**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

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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.	**0020**	**SERVICE THRU DATE > DATE RECEIVED - VERIFY SERVICE THRU DATE**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) 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.	**0022**	**INV/MISS BILLED DATE**	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0024**	**POS REVERSAL REJECTED-RESUBMIT USING FD-999 FORM.**	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0025**	**INV/MISS DISPENSED DATE**	N57 (10/16/03)	Missing/incomplete/invalid prescribing 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.	**0031**	**CONDITION CODE 85/C3 PRESENT, REQUIRES REVENUE CODE 912**	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).
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.	**0033**	**SUBMITTER ID IS NOT NUMERIC OR = "O".**	N407 (11/01/15)	You are not an approved submitter for this transmission format.
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.	**0034**	**MISSING LABORATORY SERVICE REVENUE CODE**	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0035**	**HOSPICE CLAIM - NUMBER OF UNITS NOT EQUAL TO NUMBER OF DAYS**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0036**	**INVALID ACUTE DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0037**	**INVALID SNF DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0038**	**INVALID ICF DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0039**	**INVALID RESIDENTIAL DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0040**	**INV/MISS ADMISSION DATE**	MA40 (10/16/03)	Missing/incomplete/invalid 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.	**0041**	**ADMISSION DATE > SERVICE COVERS FROM DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0042**	**INV/MISS TYPE BILL CODE**	N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0044**	**INV/MISS TYPE OF ADMISSION**	MA41 (10/16/03)	Missing/incomplete/invalid admission type.
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.	**0045**	**INV/MISS PATIENT STATUS CODE**	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
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.	**0046**	**TOTAL DAYS NOT EQUAL TO DATES OF SERVICE**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0048**	**MISSING/INV SURGICAL PROCEDURE CODE**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0049**	**INV/MISS SURG DATE - SUPPLY VALID DATE OR REMOVE PROC CODE**	N341 (01/01/14)	Missing/incomplete/invalid surgery 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.	**0050**	**BLOOD NOT REPLACED AMOUNT MUST BE NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0051**	**RENAL REVENUE IS PRESENT - RENAL BILL TYPE IS MISSING**	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
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.	**0052**	**TOTAL BLOOD PINTS FURNISHED INCORRECT**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0053**	**INV/MISS ACCOMMODATION DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0054**	**INPATIENT/INPATIENT CROSSOVER CLAIM - SWING BEDS**	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
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.	**0055**	**A 1 IS NOT PRESENT IN THE PA IND FIELD AND PA # IS PRESENT**	M62 (11/01/15)	Missing/incomplete/invalid treatment authorization 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.	**0056**	**INV/MISS REVENUE UNITS**	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0057**	**CONDITION CODE 40 - FROM/THRU NOT EQUAL**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0060**	**INV/MISS OCCURENCE CODE - SUPPLY VALID CODE OR REMOVE DATE**	M45 (11/01/15)	Missing/incomplete/invalid occurrence code(s).
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.	**0062**	**INVALID CONDITION CODE**	M44 (01/01/14)	Missing/incomplete/invalid condition 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.	**0063**	**INV/MISS ADMISSION HOUR**	N46 (10/16/03)	Missing/incomplete/invalid admission hour.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0064**	**SERVICE THRU DATE > STATEMENT THRU DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0065**	**PINTS OF BLOOD FURNISHED MUST BE NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0066**	**INVALID SPECIAL PROGRAM INDICATOR**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0067**	**INV/MISS NON COVERED HOSPITAL DAYS**	MA33 (10/16/03)	Missing/incomplete/invalid non-covered days during the billing period.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0068**	**INVALID SOURCE OF ADMISSION**	MA42 (10/16/03)	Missing/incomplete/invalid admission source.
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.	**0069**	**INVALID OCCURENCE DATE**	N300 (01/01/14)	Missing/incomplete/invalid occurrence span date(s).
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.	**0071**	**INVALID STATEMENT COVERS FROM DATE**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) 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.	**0072**	**INVALID STATEMENT COVERS THRU DATE**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0073**	**SERVICE COVERS FROM DATE < STATEMENT FROM DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
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.	**0074**	**STATEMENT COVERS FROM DATE > SERVICE THRU DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0075**	**PINTS OF BLOOD REPLACED NOT NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0079**	**INPATIENT CLAIM-REQUIRES AT LEAST ONE ACCOMMODATION REV CODE**	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0080**	**ICN DATE IS > 2 YRS FROM SERVICE DATE**	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).
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.	**0081**	**INV/MISS CLINIC CODE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0082**	**EMERG ROOM REV CODE (S) PRESENT - CLINIC CODE '00' MISSING**	N657 (11/01/15)	This should be billed with the appropriate code for these 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.	**0083**	**REV CODE 099,36X,37X,49X OR 71X REQ VALID SURGICAL PROC**	N657 (11/01/15)	This should be billed with the appropriate code for these services.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0084**	**BABY & MOTHER-ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)**	MA42 (10/16/03)	Missing/incomplete/invalid admission source.
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.	**0085**	**INV/MISS DAYS/UNITS/VISITS**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0086**	**NUMBER OF UNITS EXCEEDS MONTHS/DAYS OF SERVICE**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0087**	**CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING**	N247 (11/01/15)	Missing/incomplete/invalid assistant surgeon taxonomy.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0089**	**DATE OF SURGERY > SERVICE/STATEMENT THRU DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0091**	**INV/MISS EPSDT LABORATORY INDICATOR**	M126 (01/01/14)	Missing/incomplete/invalid individual lab codes included in the test.
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.	**0100**	**ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK**	N382 (11/01/15)	Missing/incomplete/invalid patient identifier.
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.	**0101**	**ABNOR INDIC IN THE PHYS/SCR IND NEW/PRIOR COND INVAL/MISS**	N27 (11/01/15)	Missing/incomplete/invalid treatment number.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0102**	**INV/MISS TOOTH SURFACE**	N75 (01/01/14)	Missing/incomplete/invalid tooth surface information.
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.	**0106**	**CONSECUTIVE LEAVE TYPES-OVERLAPPING DATES OF SERVICES**	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
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.	**0109**	**ALLOWABLE AMOUNT IS LESS THAN CO-PAY AMOUNT**	M79 (11/01/15)	Missing/incomplete/invalid 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.	**0111**	**LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0113**	**LTC/HOSPICE LONG TERM PSYCH CLAIM SPANS MONTHS'**	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.
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.	**0114**	**INV/MISS ADMIT CODE**	MA65 (10/16/03)	Missing/incomplete/invalid admitting 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.	**0115**	**INVALID GENERAL STATUS / DISCHARGE CODE**	N50 (10/16/03)	Missing/incomplete/invalid discharge information.
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.	**0119**	**INV/MISS LEAVE OF ABSENCE CODE**	N50 (10/16/03)	Missing/incomplete/invalid discharge information.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0123**	**EMC CLM NOT ALLOWED FOR SR GOLD CLM SUBMIT BY POS**	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
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.	**0127**	**NDC CODE MISSING OR INVALID**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**0128**	**CLAIM > $400-RESUB CLAIM VERIFYING METRIC QUANTITY REPORTED**	N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.
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.	**0129**	**INVALID ATTACHMENT CODE GREATER THAN 17**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0130**	**INV/MISS DAYS SUPPLY**	M123 (11/01/15)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
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.	**0131**	**INV/MISS PRESCRIPTION NUMBER**	N388 (11/01/15)	Missing/incomplete/invalid 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.	**0132**	**INV/MISS NURSING FACILITY (LTCF) INDICATOR**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0134**	**USE PROPER PROCEDURE CD. SEE NEWSLTR VOL 2 #61 DATED 11/92**	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0135**	**INV/MISS CURRENT EXAM DATE**	N301 (11/01/15)	Missing/incomplete/invalid procedure date(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.	**0136**	**COPAY CLAIM DENIED - NO BENEFICIARY OR PROGRAM LIABILITY**	N58 (11/01/15)	Missing/incomplete/invalid patient liability 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.	**0137**	**CURRENT EXAM GREATER THAN DATE DISPENSED**	N304 (11/01/15)	Missing/incomplete/invalid dispensed 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.	**0138**	**ACCIDENT INDICATOR MUST BE Y, N, OR SPACE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0139**	**EPSDT INDICATOR NOT Y, N OR SPACE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0140**	**LABORATORY INDICATOR MUST BE Y OR N**	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.
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.	**0141**	**INV/MISS PLACE OF SERVICE**	M77 (01/01/14)	Missing/incomplete/invalid/inappropriate 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.	**0142**	**INV/MISS ORIGIN CODE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0143**	**INV/MISS DESTINATION CODE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0147**	**FAMILY PLANNING INDICATOR MUST BE Y OR N**	N554 (11/01/15)	Missing/Incomplete/Invalid Family Planning 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.	**0149**	**CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS**	N430 (11/01/15)	Procedure code is inconsistent with the units 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.	**0150**	**INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON 1500NJ**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0151**	**INV/MISS CLAIM LINE CHARGE(S)**	M79 (11/01/15)	Missing/incomplete/invalid 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.	**0152**	**INV/MISS TOTAL CHARGE**	M54 (10/16/03)	Missing/incomplete/invalid 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.	**0153**	**INCORRECT TOTAL CHARGES**	M54 (10/16/03)	Missing/incomplete/invalid 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.	**0154**	**COINS AND/OR LIFETIME RESERVE DAYS CONFLICT WITH DOS**	MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0155**	**COINS DAYS LIFETIME RESERVE DAYS AND/OR BLD DEDUCT MISSING**	MA35 (10/16/03)	Missing/incomplete/invalid number of 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.	**0156**	**COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC**	MA35 (11/01/15)	Missing/incomplete/invalid number of 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.	**0157**	**ACUTE DAYS > 150 - RESUBMIT AS INPATIENT TPL CLAIM**	MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.
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.	**0158**	**ACUTE DAYS > 90 - RESUBMIT AS INPATIENT TPL CLAIM**	MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.

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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.	**0160**	**INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS**	N440 (11/01/15)	Incomplete/invalid anesthesia physical status report/indicators.
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.	**0161**	**INV/MISS HCPCS PROCEDURE CODE**	MA66 (10/16/03)	Missing/incomplete/invalid principal 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.	**0165**	**EMC - INVALID HCPCS PROCEDURE PREFIX**	M20 (10/16/03)	Missing/incomplete/invalid HCPCS.
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.	**0166**	**INV/MISS DIAGNOSIS CODE**	M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0167**	**MISSING PRIMARY DIAGNOSIS CODE**	M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.
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.	**0170**	**EXCESSIVE ANESTHESIA UNITS - PEND FOR MEDICAL REVIEW**	N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/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.	**0171**	**INVALID CARRIER CODE**	N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) 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.	**0172**	**INVALID PAYOR ID**	M56 (10/16/03)	Missing/incomplete/invalid payer identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0173**	**INVALID COINSURANCE DAYS**	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.
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.	**0174**	**CLAIM IS NOT XOVER - RESUBMIT AS INPATIENT HOSPITAL CLAIM**	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.
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.	**0175**	**BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC**	M79 (11/01/15)	Missing/incomplete/invalid 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.	**0176**	**MCARE DEDUCTIBLE AMOUNT MUST BE NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0177**	**MCARE COINSURANCE AMOUNT MUST BE NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(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.	**0178**	**BLOOD DEDUCTIBLE (PINTS) MUST BE NUMERIC**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0179**	**MISSING/INVALID COINSURANCE DAYS**	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing 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.	**0180**	**OTHER INSURANCE INDICATOR MUST BE Y OR N**	MA112 (01/01/14)	Missing/incomplete/invalid group practice information.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0181**	**TOTAL TPL AMOUNT MUST BE NUMERIC**	M49 (10/16/03)	Missing/incomplete/invalid value code(s) or amount(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.	**0182**	**OVERRIDE CODE NOT NUMERIC**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0183**	**MEDICARE PAYMENT DATE IS MISSING OR INVALID**	N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment 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.	**0184**	**INVALID/MISSING ADJUSTMENT REASON**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0186**	**MEDICARE ALLOWED NOT NUMERIC OR NOT > ZERO**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0187**	**DEDUCTIBLE, BLOOD DEDUCTIBLE, AND/OR COINSURANCE AMT MISSING**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(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.	**0188**	**CASH DEDUCTIBLE AMOUNT EXCEEDS THE YEARLY MAXIMUM**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0189**	**EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF**	N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0190**	**1ST 2 POSITIONS OF BILL TYPE CONFLICTS WITH THE PAYOR ID**	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
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.	**0192**	**MEDICAID NOT PRIMARY PAYOR SINCE TPL AMOUNT > ZERO**	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.
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.	**0193**	**MEDICAID CHARGES PLUS TPL AMOUNT < 50% BILLED CHARGES**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0194**	**MISSING MEDICAID CHARGES**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0195**	**CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE**	N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/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.	**0198**	**VERIFY AND/OR CORR DRG CODE**	N208 (11/01/15)	Missing/incomplete/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.	**0200**	**ATTENDING PHYSICIAN NOT ON FILE**	N253 (01/01/14)	Missing/incomplete/invalid attending provider primary identifier.
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.	**0204**	**SERVICING AND BILLING PROVIDERS NOT LINKED ON D.O.S.**	N257 (02/01/19)	Missing/incomplete/invalid billing provider/supplier primary identifier.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0205**	**SERVICING PROVIDER IS GROUP PROVIDER**	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
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.	**0206**	**BILLING PROVIDER NOT ON FILE**	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary 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.	**0208**	**PROVIDER APPROVED FOR EMC ONLY**	M77 (11/01/15)	Missing/incomplete/invalid/inappropriate 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.	**0209**	**GROUP MUST BILL FOR MEMBER OF GROUP**	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0211**	**SERVICING PROVIDER IS GROUP-GROUP HAS NO MEMBERS**	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
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.	**0218**	**REFERRING/OTHER PHYSICIAN PROVIDER NOT ON FILE**	N269 (01/01/14)	Missing/incomplete/invalid other provider name.
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.	**0220**	**CLAIM SPANS FISCAL YEAR**	MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period 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.	**0224**	**PRESCRIBING PHYSICIAN/PRACTIONER NUMBER NOT ON FILE**	N265 (01/01/14)	Missing/incomplete/invalid ordering provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0225**	**BILLING PROVIDER IS NOT A GROUP**	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
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.	**0227**	**PROVIDER NOT APPROVED FOR EMC**	N407 (11/01/15)	You are not an approved submitter for this transmission format.
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.	**0230**	**BILLING OR SERVING PROVIDER NOT VALID**	N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary 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.	**0231**	**REFERRING PROVIDER NUMBER REQUIRED - GSHP**	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0235**	**INVALID DIVISION OF JUVENILE SERVICES CLAIM.**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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.	**0238**	**PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT**	N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service 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.	**0247**	**REVENUE/ICD9/HCPCS PROC CODE ON CLM CONFLICTS WITH CLM TYPE**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
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.	**0248**	**SURGERY PROCEDURE CODE NOT ON FILE**	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0252**	**PROC/REVENUE CODE/NDC/DIAG REQUIRES REVIEW**	M119 (01/01/14)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**0257**	**PROC/NDC/REV/ICD NOT CVRD BY MA, MA-RELATED, PAAD/SR GOLD**	M50 (01/01/14)	Missing/incomplete/invalid revenue code(s).
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.	**0258**	**AMBULATORY SURGICAL CENTER-DAYS/DATES INCONSISTENT**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0259**	**HCPCS PROCEDURE CODE NOT ON FILE**	M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0260**	**DIAGNOSTIC REPORT (XRAYS,LAB,ETC.) REQUESTED**	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.
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.	**0262**	**REFER/OTHER PHY REQ FOR CONSULT AND/OR 2ND OPINION**	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.
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.	**0265**	**SERVICE NOT PAYABLE TO ASC**	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
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.	**0271**	**SUBMITTER NOT APPROVED FOR PROVIDER.**	N407 (11/01/15)	You are not an approved submitter for this transmission format.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0272**	**USE PROPER PRO CODE -SEE NEWSLETTER VOL.2 #61 DATED 11/92**	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
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.	**0273**	**PROCEDURE DOES NOT WARRANT SURGICAL ASSIST**	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service 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.	**0275**	**RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN**	N285 (11/01/15)	Missing/incomplete/invalid referring provider name.
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.	**0277**	**REFERRING PROVIDER NUMBER REQUIRED**	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0283**	**PROVIDER LIMITED TO NON-DYFS BENEFICIARIES**	M62 (11/01/15)	Missing/incomplete/invalid treatment authorization 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.	**0284**	**PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE**	N62 (01/01/14)	Dates of service span multiple rate periods. Resubmit separate claims.
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.	**0288**	**VETERANS HOME RESIDENT, NON COVERED SERVICE**	N34 (11/01/15)	Incorrect claim form/format for this 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.	**0290**	**INVALID SECONDARY DIAGNOSIS**	M64 (10/16/03)	Missing/incomplete/invalid other diagnosis.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0294**	**DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS**	MA63 (11/01/15)	Missing/incomplete/invalid principal 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.	**0295**	**INVALID THIRD OR SUBSEQUENT DIAGNOSIS.**	M64 (01/01/14)	Missing/incomplete/invalid other diagnosis.
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.	**0297**	**SERVICE PROVIDER NOT ENROLLED IN CLIA**	MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification 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.	**0298**	**SERVICE PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**	MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0302**	**NAME MISMATCH OR FOR PHARMACY: GENDER AND/OR DOB**	MA36 (01/01/14)	Missing/incomplete/invalid patient name.
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.	**0306**	**MEDICAID RECIP ID CORRECTED**	N382 (01/01/16)	Missing/incomplete/invalid patient 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.	**0311**	**CORRECT D.O.B. OR RESUBMIT CLAIM UNDER BABY'S NUMBER**	N329 (11/01/15)	Missing/incomplete/invalid patient birth 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.	**0312**	**CORRECT RECIPIENT NUMBER AND RESUBMIT**	MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0314**	**CLAIM SERV. DATES OVERLAP SPEC. PROG. ELIG. BEGIN/END DATES.**	N443 (01/01/14)	Missing/incomplete/invalid total time or begin/end time.
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.	**0319**	**INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM**	N61 (11/01/15)	Rebill services on separate claims.
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.	**0321**	**RECIPIENT NOT ON FILE**	N382 (11/01/15)	Missing/incomplete/invalid patient 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.	**0322**	**HMO COVERED SERVICE -REVIEW REQUIRED**	M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0325**	**SERVICE NOT COVERED BY HMO - RECIPIENT INELIG FOR MEDICAID**	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
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.	**0326**	**LTC RECIPIENT NOT ON FILE**	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.
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.	**0328**	**MHC RECIPIENT-NO M'CAID ELIG SEGMENT FOR THIS PERIOD**	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
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.	**0330**	**HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS**	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0331**	**SECOND OPINION REQUIRED**	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.
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.	**0333**	**INVALID/MISSING SECOND OPINION INDICATOR**	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary 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.	**0334**	**DATE OF CONS MUST BE AT LEAST 30 BUT NOT > 180 DAYS FROM DOS**	MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.
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.	**0339**	**DENY SECOND OPINION NOT OBTAINED**	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0340**	**ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE**	N34 (11/01/15)	Incorrect claim form/format for this 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.	**0342**	**RECIPIENT DATES, SIGNATURE MISSING ON HYSTER FORM**	MA75 (01/01/14)	Missing/incomplete/invalid patient or authorized representative signature.
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.	**0343**	**INVALID/MISS STERILIZATION CONSENT DATE**	MA100 (11/01/15)	Missing/incomplete/invalid date of current illness or symptoms.
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.	**0344**	**PHYSICIAN SIGN/NUMBER/DATES MISSING ON ABORTION FORM**	MA81 (01/01/14)	Missing/incomplete/invalid provider/supplier signature.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0345**	**MISSING ABORTION PROCEDURE CODE**	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure 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.	**0346**	**INVALID/MISSING STERILIZATION INTERPRETER INDICATOR**	MA58 (11/01/15)	Missing/incomplete/invalid release of information 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.	**0347**	**INVALID/MISS STERILIZATION RACE CODE**	MA58 (11/01/15)	Missing/incomplete/invalid release of information 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.	**0348**	**INVALID ABORTION CODE**	N27 (11/01/15)	Missing/incomplete/invalid treatment number.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0356**	**RECIP/PHYS DATE/SIGN MISSING ON STERILIZATION FORM**	MA71 (11/01/15)	Missing/incomplete/invalid provider representative signature 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.	**0357**	**HYSTERECTOMY RECEIPT OF INFO FORM-DATA INCORR/MISS OR ILLEG**	N34 (01/01/14)	Incorrect claim form/format for this 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.	**0360**	**PHYSICIAN SIGNATURE/DATE MISSING ON SECOND OPINION FORM**	MA70 (01/01/14)	Missing/incomplete/invalid provider representative signature.
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.	**0361**	**INSUFFICIENT MEDICAL DOCUMENTATION FOR HYSTERECTOMY**	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0362**	**CLAIM IS POSSIBLE STERILIZATION**	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
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.	**0363**	**CLAIM IS POSSIBLE ABORTION**	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
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.	**0364**	**CLAIM SPANS HMO ENROLLMENT - CALL REVS**	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(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.	**0367**	**GA RECIPIENT INELIGIBLE ON DATE OF SERVICE**	MA43 (10/16/03)	Missing/incomplete/invalid patient status.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0374**	**REPORTED SERVICE UNITS MUST BE GREATER THAN 1 & LESS THAN 6**	M53 (02/02/04)	Missing/incomplete/invalid days or units 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.	**0383**	**DATE OF SERVICE LATER THAN DATE OF DEATH**	N330 (11/01/15)	Missing/incomplete/invalid patient death 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.	**0384**	**DATE OF SERVICE LATER THAN DATE OF DEATH**	N330 (11/01/15)	Missing/incomplete/invalid patient death date.
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.	**0408**	**PRIOR AUTHORIZATION NUMBER INVALID**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0412**	**GSHP QA/QU PRIOR AUTHORIZATION REQUIRED**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**0419**	**WFNJ/GA OR NJFL CLAIM PROCESSED AS ADDP**	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
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.	**0420**	**CLAIM PAYABLE UNDER WFNJ/GA OR FC ONLY**	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
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.	**0422**	**MANAGED CARE RECIPIENT-PRIOR AUTHORIZATION REQUIRED**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0423**	**PRIOR AUTHORIZATION REQUIRED**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**0430**	**OTHER COVERAGE CODE VALUE IS INVALID**	N245 (09/01/20)	Incomplete/invalid plan information for other insurance.
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.	**0435**	**UNABLE TO DETERMINE HIPAA CLAIM TYPE.**	MA30 (10/16/03)	Missing/incomplete/invalid type of bill.
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.	**0437**	**INVALID SUBMITTED ID**	N407 (11/01/15)	You are not an approved submitter for this transmission format.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0443**	**TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT**	MA92 (09/01/20)	Missing plan information for other insurance.
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.	**0457**	**LTC FACILITY ID MISSING ON POS REBILL UNIT DOSE RESTOCK**	M44 (10/16/03)	Missing/incomplete/invalid condition 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.	**0461**	**ESRD CLAIM-OCCURRENCE CODE 35 REQUIRED**	M45 (10/16/03)	Missing/incomplete/invalid occurrence code(s).
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.	**0462**	**RENAL REVENUE CODE PRESENT - RENAL CONDITION CODE REQUIRED**	M44 (10/16/03)	Missing/incomplete/invalid condition code.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0472**	**FQHC ENCOUNT BILLED UNITS GT PAID HCPCS UNITS ON HIST**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0473**	**TOTAL CALCULATED CHARGE NOT EQUAL TO TOTAL BILLED CHARGE**	M54 (10/16/03)	Missing/incomplete/invalid 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.	**0474**	**NET CALCULATED CHARGES NOT EQUAL TO NET BILLED CHARGE**	M54 (10/16/03)	Missing/incomplete/invalid total 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.	**0496**	**INVALID BIRTH WEIGHT / DRG**	N207 (11/01/15)	Missing/incomplete/invalid weight.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0499**	**ACUTE DAYS BILLED EQUAL ZERO**	N306 (11/01/15)	Missing/incomplete/invalid acute manifestation 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.	**0503**	**REVENUE CODE NOT ON FILE**	M50 (10/16/03)	Missing/incomplete/invalid revenue code(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.	**0508**	**PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED**	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
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.	**0510**	**COINS DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS**	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0513**	**LTC CROSSOVER CLAIM REQUIRES A MEDICARE PER DIEM RATE**	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.
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.	**0514**	**NURSING FACILITY LEAVE/RETURN RESTRICTED**	N50 (10/16/03)	Missing/incomplete/invalid discharge information.
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.	**0515**	**NURSING FACILITY ADMIT RESTRICTED**	MA40 (11/01/15)	Missing/incomplete/invalid admission 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.	**0522**	**INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM**	N32 (11/01/15)	Claim must be submitted by the provider who rendered the service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0542**	**NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**0549**	**DRUG NOT PAYABLE - NO REBATE AGREEMENT**		
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.	**0551**	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**0553**	**COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0559**	**COMPOUND DRUG-NDC CODE MISSING OR INVALID**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**0560**	**COMPOUND DRUG-QUANTITY MISSING OR INVALID**	M123 (10/16/03)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
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.	**0574**	**CAPITATION RATE NOT FOUND FOR CLAIM DOS**	N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0575**	**NO GSHP PCM RATE NOT FOUND FOR CLAIM SERVICE DATE**	N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0577**	**PA REQUIRED FOR WFNJ/GA DRUG COVERAGE**	M62 (09/01/20)	Missing/incomplete/invalid treatment authorization 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.	**0579**	**PROVIDER IRS NUM REQUIRED FOR SPECIAL EDUC CLAIM**	N77 (11/01/15)	Missing/incomplete/invalid designated provider number.
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.	**0580**	**CLAIM ERROR REASONS > 10**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0582**	**MISSING/INVALID TOOTH SURFACE**	N75 (10/16/03)	Missing/incomplete/invalid tooth surface information.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0585**	**SERVICE UNITS INCONSISTENT WITH PRODUCT PACKAGING**	M53 (09/01/20)	Missing/incomplete/invalid days or units 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.	**0586**	**MISSING/INVALID TOOTH QUADRANT**	N75 (11/01/15)	Missing/incomplete/invalid tooth surface information.
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.	**0587**	**MISSING/INVALID TOOTH NUMBER**	N37 (11/01/15)	Missing/incomplete/invalid tooth number/letter.
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.	**0588**	**OTHER PAYER CHGS ARE MISSING VALUE CODE 24 AND AMOUNT REQ**	M54 (01/01/14)	Missing/incomplete/invalid total charges.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0591**	**PROVIDER NOT ON PROVIDER RATE FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0592**	**CAPITATION CATEGORY NOT ON GSHP RATE FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/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.	**0594**	**CLAIM NOT ELIGIBLE FOR ADD-ON DATE OF SERVICE**	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.
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.	**0595**	**REV CODE/COND CODE CONFLICT FOR COMPOSITE RATE PRICING**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0596**	**PHARMACY CAPITATION RATE LEVEL NOT IN EFFECT FOR DOS**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0599**	**INVALID LTC COUNTY OF CHARGE**	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).
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.	**0602**	**MISSING OR INVALID DRG CODE**	N208 (11/01/15)	Missing/incomplete/invalid DRG 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.	**0604**	**INVALID PRICING ACTION CODE**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0607**	**LOW VARIANCE ERROR**	M79 (02/01/16)	Missing/incomplete/invalid 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.	**0609**	**DRG DIRECT COST, LOW TRIM OR HIGH TRIM PER DIEM EQUAL ZERO**	N208 (11/01/15)	Missing/incomplete/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.	**0612**	**PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE**	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.
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.	**0618**	**VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0621**	**DRG CODE NOT ON FILE**	N208 (01/01/14)	Missing/incomplete/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.	**0624**	**NO VALID PRICE FOR DATE OF SERVICE ON USUAL & CUSTOMARY FILE**	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.
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.	**0639**	**REFERRING PROVIDER MUST BE NURSING FACILITY**	N276 (11/01/15)	Missing/incomplete/invalid other payer referring 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.	**0642**	**RESUBMIT CLM WITH INVOICE OR MANUFACTURER'S PRICE LIST**	N63 (11/01/15)	Rebill services on separate claim lines.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0643**	**OUT OF REGION NON-DRG HOSPITAL REQ MAN PRICING FOR DOS**	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of 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.	**0644**	**OUT OF REG NON-DRG HOSP REQ MAN PRICING-NO PROV RATE RECORD**	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
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.	**0646**	**MISSING NEW YORK REGIONAL BAD DEBT MULTIPLIER**	M79 (11/01/15)	Missing/incomplete/invalid 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.	**0647**	**MISSING PENNSYLVANIA DRG EXEMPT PER DIEM RATE**	N213 (11/01/15)	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0648**	**INVALID NEW YORK EXEMPT UNIT RATE CODE**	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate 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.	**0649**	**MISSING NEW YORK EXEMPT UNIT RATE DATA**	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.
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.	**0657**	**MISSING NJ DRG PAYOR FACTOR**	N208 (05/01/16)	Missing/incomplete/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.	**0658**	**NO PROVIDER RATE RECORD FOR BILLING PROVIDER**	N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0659**	**NF RATE NOT ON FILE**	N471 (11/01/15)	Missing/incomplete/invalid HIPPS 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.	**0660**	**NUMBER OF ACCOMMODATION DAYS NOT EQUAL TO TOTAL BILLED DAYS**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**0661**	**INV/MISS DRG CODE**	N208 (11/01/15)	Missing/incomplete/invalid DRG 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.	**0663**	**USE PROPER PROCEDURE CODE-SEE NEWSLETTER P669 DATED 08/91**	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0668**	**USE ASSIGNED PROC CODE/NDC CODE TO MATCH DESCRIPTION GIVEN**	M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).
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.	**0671**	**MEDICARE RATE NOT ON FILE**	N471 (11/01/15)	Missing/incomplete/invalid HIPPS 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.	**0704**	**OUTPATIENT ACUTE-ADULT PARTIAL HOSPITALIZATION - PA REQUIRED**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization 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.	**0708**	**GLOBAL OB CARE/SERVICE CONFLICT**	M67 (10/16/03)	Missing/incomplete/invalid other procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0726**	**INDIVID LAB TESTS EXCEEDS PANEL ALLOWANCE -REDUCED PAYMENT.**	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.
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.	**0727**	**INDIVIDUAL LAB TESTS ALLOWANCE EXCEEDS PANEL ALLOWANCE**	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.
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.	**0728**	**INDIVIDUAL LAB TEST/CBC CONFLICT**	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.
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.	**0770**	**PROCEDURE CODE/NDC NOT INCLUDED IN PRIOR AUTHORIZATION**	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0771**	**DAY SUPPLY INCORRECTLY REPORTED AS ONE DAY.**	M53 (10/16/03)	Missing/incomplete/invalid days or units 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.	**0778**	**NO IMMUNIZATION CODE PROVIDED ON THE SAME DAY OF SERVICE**	N20 (11/01/15)	Service not payable with other service rendered on the same 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.	**0786**	**PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED-RESUBMIT CLAIM**	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement 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.	**0789**	**FORMER ICN INVALID (FFS)**	M122 (01/01/16)	Missing/incomplete/invalid level of subluxation.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0796**	**BILLING PROVIDER NOT MATCHED ON HISTORY**	N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.
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.	**0799**	**NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**	N5 (08/31/04)	EOB received from previous payer. Claim 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.	**0841**	**PROVIDER CANNOT BE SURGEON & ASST SURGEON/ANESTHESIOLOGIST**	N250 (01/01/14)	Missing/incomplete/invalid assistant surgeon secondary identifier.
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.	**0943**	**REBILL CLAIM WITH MEDICARE PAID LINES ONLY**	N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0944**	**PROCEDURE CODE AND/OR CHARGES ON CLAIM DO NOT MATCH EOB**	N34 (11/01/15)	Incorrect claim form/format for this 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.	**0946**	**RA SHOWING MEDICAID CROSSOVER PAYMENT MUST BE ATTACHED**	MA92 (01/01/14)	Missing plan information for other insurance.
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.	**0947**	**MEDICARE OUTPATIENT PART B EOB MISSING**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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.	**0955**	**CLAIM VOIDED - RESUBMITTED AS ORIGINAL CLAIM**	N142 (01/01/16)	The original claim was denied. Resubmit a new claim, not a replacement claim.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0972**	**NO EOB ATTACHED-RECIPIENT WITH OTHER RESOURCE INDICATED**	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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.	**0981**	**BENEFICIARY/DATES OF SERVICE DO NOT MATCH EOB/LETTER**	M59 (01/29/16)	Missing/incomplete/invalid 'to' date(s) of service.
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.	**0982**	**EOB INDICATES BILLING ERROR, REVIEW OR REBILL TO CARRIER**	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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.	**0983**	**RESOURCE FILE INDICATES INSURANCE OTHER THAN PAYOR ID CODED**	M56 (01/01/14)	Missing/incomplete/invalid payer identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0984**	**CLAIM REQUIRES REVIEW - MEDICARE PART B ATTACHMENT**	N480 (01/29/16)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
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.	**0985**	**ENTER TPL AMT PAID FROM EOB IN PRIOR PMT BOX ON CLAIM FORM**	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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.	**0986**	**INVALID PAYOR ID**	M56 (10/16/03)	Missing/incomplete/invalid payer identifier.
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.	**0988**	**NEGATIVE MEDICARE EOB, REBILL AS ZERO PRIOR PAY**	N480 (11/01/15)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0989**	**INVALID APPROPRIATION CODE ASSIGNMENT**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**0994**	**NO MATCHING PA MASTER FOR AJ CREDIT**	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(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.	**0998**	**INCORRECT PAAD CLAIM**	N34 (11/01/15)	Incorrect claim form/format for this 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.	**0999**	**PROCESSING ERROR/CLAIM WAS RESUBMITTED BY FISCAL AGENT**	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1001**	**REVENUE UNITS (OCCURS 45 TIMES) ARE GREATER THAN 999**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**1002**	**DAYS ACUTE ARE GREATER THAN 999**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**1003**	**DAYS SNF ARE GREATER THAN 999**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**1004**	**DAYS ICF ARE GREATER THAN 999**	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1005**	**DAYS RESIDENTIAL ARE > 999**	M53 (11/01/15)	Missing/incomplete/invalid days or units 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.	**1010**	**INVALID LTC PATIENT/OTHER PAYMENT AMOUNT**	M79 (11/01/15)	Missing/incomplete/invalid charge.
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.	**1022**	**CAPITATION PAYMENT REDUCED BY MAX PATIENT PAYMENT LIABILITY**	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.
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.	**1025**	**CAP PAYMENT PART REDUCED BY MAX PATIENT LIABILITY**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1200**	**OCC SPAN DAY DOES NOT MATCH THE NUMBER OF REVENUE UNITS**	M46 (01/01/14)	Missing/incomplete/invalid occurrence span code(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.	**1209**	**DOS SPANS PROVIDER FISCAL YR, MULTIPLE RATE USED FOR PRICING**	N62 (11/01/15)	Dates of service span multiple rate periods. Resubmit separate claims.
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.	**1214**	**INVALID NDC OR NDC NOT ON FILE**	M119 (06/04/07)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**1215**	**PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE**	M20 (06/04/07)	Missing/incomplete/invalid HCPCS.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1217**	**TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER**	N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.
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.	**1218**	**TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER**	N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.
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.	**1219**	**TAXONOMY CODE IS MISSING FOR SERVICING PROVIDER**	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.
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.	**1220**	**TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER**	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1221**	**NPI IS MISSING FOR SERVICE/RENDERING PROVIDER**	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.
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.	**1222**	**NPI IS INVALID FOR SERVICE/RENDERING PROVIDER**	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary 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.	**1223**	**NPI IS MISSING FOR ATTENDING PROVIDER**	N252 (01/15/13)	Missing/incomplete/invalid attending provider name.
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.	**1224**	**NPI IS INVALID FOR ATTENDING PROVIDER**	N252 (01/15/13)	Missing/incomplete/invalid attending provider name.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1226**	**NPI IS INVALID FOR REFERRING PROVIDER**	N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.
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.	**1227**	**NPI IS MISSING FOR OPERATING PROVIDER**	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1228**	**NPI INVALID - UB04 OPERATING 1 PROVIDER**	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1229**	**NPI IS MISSING FOR BILLING PROVIDER**	N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1230**	**NPI IS INVALID FOR BILLING PROVIDER**	N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.
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.	**1231**	**NPI IS MISSING FOR OTHER PROVIDER**	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.
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.	**1232**	**NPI IS INVALID FOR OTHER PROVIDER**	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.
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.	**1233**	**NPI MISSING FOR PRESCRIBING PROVIDER**	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1234**	**NPI INVALID FOR PRESCRIBING PROVIDER**	N265 (01/15/13)	Missing/incomplete/invalid ordering provider primary identifier.
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.	**1235**	**NPI NOT ON FILE FOR SERVICE/RENDERING PROVIDER**	M49 (05/23/07)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**1236**	**ZIP CODE IS MISSING OR INVALID**	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.
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.	**1237**	**NPI NOT CROSSWALKED - SERV/REND**	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1238**	**PROVIDER NOT MATCHED - SERV/REND**	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.
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.	**1240**	**NPI NOT CROSSWALKED - BILLING**	N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.
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.	**1241**	**PROVIDER NOT MATCHED - BILLING**	N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.
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.	**1242**	**PROVIDER ID AND NPI REQUIRED - BILLING**	N259 (01/01/13)	Missing/incomplete/invalid billing provider/supplier secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1243**	**NPI NOT CROSSWALKED - ATTENDING**	N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.
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.	**1244**	**PROVIDER NOT MATCHED - ATTENDING**	N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.
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.	**1245**	**PROVIDER ID AND NPI REQUIRED - SERVICING**	N291 (01/01/13)	Missing/incomplete/invalid rendering provider secondary identifier.
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.	**1246**	**NPI NOT CROSSWALKED - UB04 REFERRING PROVIDER**	N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1247**	**PROVIDER NOT MATCHED - REFERRING**	N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.
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.	**1252**	**MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT**	MA34 (11/01/15)	Missing/incomplete/invalid number of coinsurance days during the billing period.
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.	**1258**	**SERVICES PAID AT CHILDREN'S RATE**	N45 (01/01/08)	Payment based on authorized amount.
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.	**1260**	**PROVIDER ID AND NPI REQUIRED - ATTENDING**	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1261**	**NPI NOT CROSSWALKED - OPERATING**	N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1262**	**PROVIDER NOT MATCHED - UB04 OPERATING 1 PROVIDER**	N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1263**	**PROVIDER ID AND NPI REQUIRED - REFERRING**	N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.
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.	**1264**	**NPI NOT CROSSWALKED - OTHER**	N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1265**	**PROVIDER NOT MATCHED - OTHER**	N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.
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.	**1266**	**PROVIDER ID AND NPI REQUIRED - OPERATING 1**	N263 (01/01/13)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1267**	**NPI NOT CROSSWALKED - PRESCRIBING**	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.
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.	**1268**	**PROVIDER NOT MATCHED- PRESCRIBING**	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1269**	**ATTENDING NPI SAME AS BILLING/SERVICING NPI**	N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.
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.	**1270**	**REFERRING NPI SAME AS BILLING/SERVICING NPI**	N286 (07/01/08)	Missing/incomplete/invalid referring provider primary identifier.
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.	**1271**	**OTHER NPI SAME AS BILLING/SERVICING NPI**	N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.
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.	**1280**	**NPI INVALID - UB04 OPERATING 2 PROVIDER**	N262 (09/07/10)	Missing/incomplete/invalid operating provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1281**	**UB04 OPERATING 1 NPI SAME AS BILLING/SERVICING NPI.**	N262 (01/15/13)	Missing/incomplete/invalid operating provider primary identifier.
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.	**1282**	**NPI NOT CROSSWALKED-UB04 OPERATING 2 PROVIDER**	N263 (09/07/10)	Missing/incomplete/invalid operating provider secondary 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.	**1284**	**INVALID/MISSING UB04 OCCURRENCE SPAN CODE**	M46 (11/01/15)	Missing/incomplete/invalid occurrence span code(s).
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.	**1285**	**INVALID UB04 OCCURRENCE SPAN FROM DATE**	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1286**	**INVALID UB04 OCCURRENCE SPAN THRU DATE**	N46 (09/07/10)	Missing/incomplete/invalid admission hour.
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.	**1287**	**STATEMENT THRU DATE < UB04 OCCUR SPAN THRU DATE**	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).
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.	**1290**	**UB04 PAT RSN VISIT REQD - UNSCHEDULED VISIT**	M64 (11/01/15)	Missing/incomplete/invalid other 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.	**1295**	**UB04 OPERATING 2 NPI. SAME AS BILLING/SERVICE NPI.**	N253 (09/07/10)	Missing/incomplete/invalid attending provider primary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1296**	**PROVIDER ID AND NPI REQUIRED - OPERATING 2**	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.
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.	**1297**	**BILLING ZIP CODE IS MISSING OR INVALID**	N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.
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.	**1298**	**TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER**	N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.
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.	**1299**	**TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER**	N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1305**	**INVALID SUPERVISING MEDICAID PROVIDER ID.**	N297 (11/01/15)	Missing/incomplete/invalid supervising provider primary identifier.
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.	**1306**	**NPI IS INVALID FOR SUPERVISING PROVIDER**	N290 (05/09/11)	Missing/incomplete/invalid rendering provider primary identifier.
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.	**1307**	**NPI NOT CROSSWALKED - SUPERVISING PROVIDER**	N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.
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.	**1309**	**SUPERVISING PROVIDER NOT ON FILE**	N31 (05/09/11)	Missing/incomplete/invalid prescribing provider identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1310**	**MISSING/INVALID DENTAL CLINIC REV CODE.**	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).
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.	**1311**	**MISSING/INVALID DENTAL PROCEDURE CODE.**	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
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.	**1312**	**MISSING OR INVALID PRESENT ON ADMISSION INDICATOR.**	N434 (12/09/13)	Missing/Incomplete/Invalid Present on Admission indicator.
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.	**1317**	**INVALID/MISSING METRIC QUANTITY**	M123 (06/08/09)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1320**	**POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE.**	N434 (11/01/15)	Missing/Incomplete/Invalid Present on Admission indicator.
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.	**1321**	**CLAIM UOM INVALID OR NOT = NDC UOM - SEE WWW.NJMMIS.COM**	M49 (06/08/09)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**1324**	**EFFECT 1/1/2012 PYMT WILL BE DEFERRED PENDING ACH ENROLLMENT**	M56 (11/01/15)	Missing/incomplete/invalid payer 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.	**1330**	**METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED**	N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1332**	**UNSUBMITTED TAXONOMY CODE WAS DEFAULTED**	N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.
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.	**1339**	**RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS**	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.
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.	**1342**	**TENT PAY PRICE USING PHY FEE INCREASE-AFFORDABLE CARE ACT**	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.
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.	**1343**	**ADV PRACTICE NURSE INELIGIBLE TO RECEIVE ACA ENHANCED PAYMNT**	MA112 (01/01/16)	Missing/incomplete/invalid group practice information.

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Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1344**	**BIRTH WEIGHT ON CLAIM AND DRG CONFLICT**	N207 (09/09/13)	Missing/incomplete/invalid weight.
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.	**1345**	**RESUBMIT CLAIM WITH ELIGIBLE MEDICAID RECIPIENT ID**	MA27 (12/01/14)	Missing/incomplete/invalid entitlement number or name shown on the 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.	**1352**	**DME AUDIT - NO DOCUMENTATION - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1353**	**DME AUDIT - INCORRECT RECIP IDENT - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1354**	**DME AUDIT - NO PROOF OF PURCHADE - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1355**	**DME AUDIT - NO PROOF OF DELIVERY - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1356**	**DME AUDIT - NO PRESCRIBER ORDER - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1357**	**DME AUDIT - DIFFERENT PROC/PRODUCT - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1358**	**DME AUDIT - DIFFERENT QTY BILLED/AUTH - (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1359**	**DME AUDIT - DIFFERENT PROC BILLED/AUTH - CALL (800-310-0865)**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1360**	**DME AUDIT - NO PRICE LIST - CALL (800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1361**	**DME AUDIT- INVALID DATE OF SERVICE - CALL(800) 310-0865**	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1362**	**LTC XOVER MISSING MCARE PAID &/OR MCARE COV DAYS &/OR COINS**	M79 (11/01/15)	Missing/incomplete/invalid charge.
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.	**1365**	**HMS PERMEDION NJUR**	M129 (10/01/20)	Missing/incomplete/invalid indicator of x-ray availability for 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.	**1366**	**HMS RECOVERY - PATIENT DECEASED ON DOS**	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.
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.	**1375**	**HMS CREDIT BALANCE RECOVERY - ON-SITE FINANCIAL REVIEW**	M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1379**	**PMT AMT ON THE APPROVED HMS ADJ GT THAN OR EQUAL TO ORIG PMT**	N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment 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.	**1387**	**PROVIDER ID AND NPI REQUIRED - PRESCRIBING**	N31 (01/01/13)	Missing/incomplete/invalid prescribing provider identifier.
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.	**1389**	**ATTENDING PROVIDER INELIGIBLE ON DATES OF SERVICE**	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.
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.	**1392**	**OPERATING 1 PROVIDER INELIGIBLE ON DATES OF SERVICE**	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1393**	**OPERATING 2 PROVIDER INELIGIBLE ON DATES OF SERVICE**	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.
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.	**1394**	**SUPERVISING PROVIDER INELIGIBLE ON DATES OF SERVICE**	N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.
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.	**1395**	**ATTENDING PROVIDER NOT FOUND ON PROVIDER DATABASE**	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.
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.	**1396**	**PRESCRIBING PROVIDER NOT FOUND ON PROVIDER DATABASE**	N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1397**	**REFERRING PROVIDER NOT FOUND ON PROVIDER DATABASE**	N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.
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.	**1398**	**OPERATING 1 PROVIDER NOT FOUND ON PROVIDER DATABASE**	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
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.	**1399**	**OPERATING 2 PROVIDER NOT FOUND ON PROVIDER DATABASE**	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary 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.	**1400**	**NO OCCURRENCE SPAN CODE 74 OR 77**	M46 (12/09/13)	Missing/incomplete/invalid occurrence span code(s).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1402**	**SUPERVISING PROVIDER NOT FOUND ON PROVIDER DATABASE**	N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.
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.	**1403**	**NPI NOT CROSSWALKED-ATTENDING**	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary 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.	**1404**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - BILLING**	N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.
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.	**1405**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SERVICING**	N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.

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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.	**1406**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - ATTENDING**	N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.
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.	**1410**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - REFERRING**	N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.
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.	**1411**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 1**	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.
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.	**1412**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 2**	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1413**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - PRESCRIBING**	N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.
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.	**1414**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SUPERVISING**	N297 (07/14/14)	Missing/incomplete/invalid supervising provider primary identifier.
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.	**1415**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - BILLING**	N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.
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.	**1416**	**ICD VERSION MISMATCH**	M64 (10/01/14)	Missing/incomplete/invalid other diagnosis.

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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.	**1418**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SERVICING**	N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.
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.	**1419**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - ATTENDING**	N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.
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.	**1420**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - REFERRING**	N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.
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.	**1421**	**NPI NOT MAPPED WITH NEW JERSEY PROVIDER ID - OPERATING 1**	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.

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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.	**1422**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 2**	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.
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.	**1423**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - PRESCRIBING**	N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.
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.	**1425**	**INVALID DIAGNOSIS FOR SERVICE**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1427**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SUPERVISING**	N291 (07/14/14)	Missing/incomplete/invalid rendering provider secondary identifier.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1428**	**UNSPECIFIED DIAGNOSIS CODE**	M81 (10/01/14)	You are required to code to the highest level of specificity.
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.	**1430**	**OUTPATIENT TRANSPORTATION SERVICE HAS NO RATE**	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.
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.	**1431**	**OUTPATIENT SERVICE NOT PAYABLE TRANS/PERS**	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.
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.	**1438**	**HOSPICE SERVICE INTENSITY ADD-ON LIMIT EXCEEDED**	N56 (01/01/16)	Procedure code billed is not correct/valid for the services billed or the date of service billed.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1439**	**ROUTINE HOME CARE HOSPICE WITH MOD 22 PRICED AT LOWER RATE**	N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.
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.	**1440**	**PROCEDURE NEEDS A DATE OF DEATH TO BE PROCESSED**	N330 (01/01/16)	Missing/incomplete/invalid patient death 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.	**1441**	**RECIP OUTSIDE 60 DAYS NOT ELIGIBLE FOR HIGHER HOSPICE RATE**	N657 (01/01/16)	This should be billed with the appropriate code for these services.
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.	**1442**	**CLAIMS REPROCESS FOR DSNP MEMBERS**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1443**	**HOSPICE DOS OVERLAP THE FIRST 60 DAYS OF HOSPICE CARE**	N62 (01/01/16)	Dates of service span multiple rate periods. Resubmit separate claims.
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.	**1444**	**SERVICE INTENSITY ADD-ON PROCEDURE BEYOND 7 DAYS**	N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.
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.	**1449**	**ICD10 SURG PROC CD MAINTENANCE. REPROCESS ON APPROVAL.**	M51 (10/03/16)	Missing/incomplete/invalid procedure code(s).
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.	**1450**	**ICD10 DIAG CD MAINTENANCE. REPROCESS ON APPROVAL.**	M51 (10/31/16)	Missing/incomplete/invalid procedure code(s).

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1451**	**UNKNOWN FIELD POPULATED WITH INVALID DATA**	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.
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.	**1456**	**PENDING IME ROOM & BOARD CHANGES FOR SUD. REPROCESS ON APPVL**	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.
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.	**1457**	**PEND ALL CLAIMS FOR PROCEDURE CODE 97127HI**	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.
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.	**1460**	**CMS PROC CODE MAINTENANCE. REPROCESS ON APPROVAL**	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.

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Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1461**	**INCORRECT SUBMITTER ID FOR EVV SERVICE**	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.
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.	**1462**	**INCORRECT SUBMITTER ID FOR EVV SERVICE**	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.
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.	**1602**	**OP PSYCH SERVICE IN CONFLICT WITH Y99XX CLAIM**	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).
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.	**1616**	**FQHC HCPCS WITH NO ENCOUNTER FOUND**	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1633**	**PA REQUIRED FOR PARTIAL CARE**	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.
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.	**1634**	**NON-EMERGENCY TRANSPORTATION PROCEDURE**	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).
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.	**1635**	**ORIGINAL APPRP CODE NOT IN USE, FIELD UPDATED**	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.
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.	**1636**	**MEDICARE CROSSOVER CLAIM PAID AND DUPLICATE DME CLAIM VOIDED**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1640**	**HOSPICE TRANSFER DAY OF DISCHARGE PAYMENT CUTBACK**	MA31 (01/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.
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.	**1643**	**CLAIM VOID PENDED - UNCONFIRMED RECIPIENT DEATH**	N330 (11/01/15)	Missing/incomplete/invalid patient death 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.	**1644**	**CLAIM VOIDED - RECIPIENT DEATH**	N330 (11/01/15)	Missing/incomplete/invalid patient death 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.	**1645**	**HMS MEDICARE COVERAGE IS NOT PRESENT ON TPL**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1650**	**MISSING QUALIFYING OTHER PROCEDURE ON DAY OF SERVICE**	N302 (11/01/15)	Missing/incomplete/invalid other procedure date(s).
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.	**1653**	**PAYMT BASED ON AFFORDABLE CARE ACT ENHANCED RATES CY 13 & 14**	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).
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.	**1654**	**RECIPIENT INELIGIBLE FOR ACA TITLE 19**	MA43 (01/01/14)	Missing/incomplete/invalid patient status.
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.	**1660**	**NO APPROPRIATE E&M, MH OR SUD CODE IN HISTORY**	N657 (11/01/15)	This should be billed with the appropriate code for these services.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1663**	**CLAIM VOIDED - PARIS MATCH**	N424 (08/01/24)	Patient does not reside in the geographic area required for this type of payment.
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.	**1669**	**NO RECORD OF AN EPISODE OF CARE ON FILE**	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of 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.	**1671**	**SERVICE DATE/HCPCS COMBINATION MATCH OCCURRENCE IN HISTORY**	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.
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.	**1674**	**REPROCESS PE CLAIMS NOW ELIGIBLE FOR NEW ADULT GROUP**	MA67 (06/08/15)	Alert: Correction to a prior claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1712**	**DIABETES SERVICES CLM HAS NO REQ'D PREV CLMS ON HISTORY**	M53 (11/22/22)	Missing/incomplete/invalid days or units of service.
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.	**1808**	**CLAIM CHECK: INVALID PROCEDURE CODE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(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.	**1809**	**CLAIM CHECK: DOB CANNOT BE GREATER THAN DATE OF SERVICE**	N329 (01/01/14)	Missing/incomplete/invalid patient birth 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.	**1811**	**CLAIM CHECK: PROCEDURE CODE IS OBSOLETE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1819**	**CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS**	N345 (06/18/07)	Date range not valid with units submitted.
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.	**1820**	**CLAIM CHECK: DATE OF SERVICE IS A FUTURE DATE**	M52 (06/18/07)	Missing/incomplete/invalid 'from' date(s) of service.
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.	**1821**	**CLAIM CHECK: BIRTH DATE IS A FUTURE DATE**	N329 (01/01/14)	Missing/incomplete/invalid patient birth 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.	**1822**	**CLAIM CHECK: MISSING PROCEDURE CODE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1823**	**CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS**	N345 (06/18/07)	Date range not valid with units submitted.
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.	**1829**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE**	MA39 (11/01/15)	Missing/incomplete/invalid gender.
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.	**1830**	**CLAIM CHECK: NUMBER OF PROCEDURES IS GREATER THAN 100**	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).
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.	**1849**	**CLAIM CHECK: INVALID DATE OF BIRTH CENTURY VALUE**	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1850**	**CLAIM CHECK: INVALID DATE OF BIRTH**	N329 (01/01/14)	Missing/incomplete/invalid patient birth 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.	**1851**	**CLAIM CHECK: INVALID CLAIM DATE OF SERVICE**	M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) 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.	**1852**	**CLAIM CHECK: INVALID DATE OF SERVICE**	M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) 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.	**1853**	**CLAIM CHECK: INVALID CHARGE AMOUNT**	M54 (06/18/07)	Missing/incomplete/invalid total charges.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1854**	**CLAIM CHECK: INVALID NUMERIC FIELD**	M79 (12/12/07)	Missing/incomplete/invalid charge.
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.	**1857**	**CLAIM CHECK: NUMERIC FIELD NOT POPULATED**	M79 (12/12/07)	Missing/incomplete/invalid charge.
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.	**1862**	**CLAIM CHECK: MISSING PROVIDER ON CLAIM**	N32 (06/18/07)	Claim must be submitted by the provider who rendered the 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.	**1877**	**CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS**	M51 (01/01/13)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1882**	**CLAIM CHECK: ASSISTANT SURGEON DENIED**	N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.
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.	**1883**	**CLAIM CHECK: ASSISTANT AT SURGERY DENIED**	N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.
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.	**1885**	**CLAIM CHECK: CCI INCIDENTAL PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
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.	**1886**	**CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1887**	**CLAIM CHECK: INCIDENTAL PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
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.	**1889**	**CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
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.	**1896**	**CLAIM CHECK: MEDICAL VISIT PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
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.	**1897**	**CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE**	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2007**	**PA INDICATOR ON THE DRUG FILE IS = 'A' OR 'Y'**		
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.	**2010**	**WRONG PCN (104-A4) - VALUE MUST = SUPPNJ, ADDP, OR PAAD**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2038**	**FIRST FILL OF THIS DRUG (BY NDC/GCN/STC) REQUIRES PRIOR AUTH**		
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.	**2048**	**PHARMACY NOT APPROVED STATE PROVIDER**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2053**	**PART D REJECT CODE CONFLICTS WITH PDP PAYMENT AMOUNT**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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.	**2076**	**SENIOR GOLD RECIPIENT W/MEDICAID ELIGIBILITY**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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.	**2099**	**INCORRECT UNIT OF MEASURE REPORTED FOR DRUG**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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 (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.	**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.	**2144**	**ADDP PARTD-SUBMIT 10-DIGIT ADDP ID NUMBER NOT HBID NUMBER**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2147**	**5.1 VERSION NOT ALLOWED FOR SUBMITTER APPROVED FOR D.O**	N251 (09/01/20)	Missing/incomplete/invalid attending provider taxonomy.
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.	**2148**	**PA NUMBER INPUT REQUIRES SPECIAL FORMAT FOR HMS TPL CLAIMS**	M62 (09/01/20)	Missing/incomplete/invalid treatment authorization 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.	**2150**	**HMS AUDITORS NOT ALLOWED IN PHARMACY**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2152**	**CLAIM DOES NOT BELONG TO PHARMACY**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2155**	**CLAIM WAS PREVIOUSLY RESERVED BY THE PHARMACY**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2158**	**DS AND QTY CHANGED TO BE CONSISTENT WITH DOCTOR'S DIRECTIONS**	M53 (09/01/20)	Missing/incomplete/invalid days or units 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.	**2159**	**RX INCOMPLETE-MISSING/INCOMP/AMBIG PRESRBRS AUTH AGENT**	N668 (09/01/20)	Incomplete/invalid prescription.
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.	**2160**	**WRONG DAYS SUPPLY; CHNGED TO BE CONSISTENT W/ DR'S DIRCTNS**	M53 (09/01/20)	Missing/incomplete/invalid days or units of service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2161**	**ERRONEOUS CLAIM**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2163**	**MISSING INGREDIENTS**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2164**	**DRUG BILLED IS DIFFERENT THAN PRESCRIBED/DISPENSED**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2165**	**INCORRECT QUANTITY BILLED FOR SINGLE PACKAGE ITEM**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2167**	**RESPONSE RECEIVED AFTER ALLOTTED TIMEFRAME**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2168**	**MISSING FAX HEADER**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2169**	**RX IS NOT ON FILE OR INCOMPLETE**	N388 (09/01/20)	Missing/incomplete/invalid prescription number.
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.	**2170**	**ACQUISITION INVOICE DOES NOT SUPPORT NDC BILLED**	N657 (09/01/20)	This should be billed with the appropriate code for these services.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2171**	**PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**2172**	**INCORRECT OR INVALID DAW/DNS SUBMITTED**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**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**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2183**	**EXCEEDED REFILLS ALLOWED**	N657 (09/01/20)	This should be billed with the appropriate code for these services.
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.	**2191**	**COPY OF RX WAS NOT PROVIDED**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**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.	**2201**	**INCORRECT/INVALID DATE RANGE ON INVOICE FOR NDC ON CLAIM**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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.	**2211**	**INSUFFICIENT INVOICE QUANTITY**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2213**	**INSUFFICIENT QTY-INVOICE DOC DOES NOT SUPPORT QTY BILLED**		
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.	**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**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2238**	**OTHER PAYER-PATIENT RESP AMT DOES NOT HAVE A CORRESP QUAL**		
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.	**2279**	**CLAIM SERVICE DATE OCCURS DURING DISASTER SITUATION**	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.
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.	**2286**	**FACILITY ID NPI IS NOT NUMERIC OR CHECK DIGIT IS INVALID**	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.
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.	**2287**	**FACILITY ID NPI NOT VALID ON NPPES PROVIDER DATABASE**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2288**	**FACILITY NPI CANNOT BE MAPPED TO A MEDICAID ID**	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.
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.	**2289**	**FACILITY ID NPI MAPS TO A NON-LTC MEDICAID PROVIDER**	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.
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.	**2298**	**SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY**	N31 (01/01/19)	Missing/incomplete/invalid prescribing provider identifier.
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.	**2325**	**OPIOID DRUG NOT FOUND ON MME FACTOR TABLE**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2327**	**450-EF COMPOUND DOSAGE FORM DESCRIPTION CODE IS INVALID**	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.
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.	**2329**	**OPIOID NOT FOUND ON RGCNSTR0 TABLE**	M119 (09/01/20)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**2354**	**PAAD RECIPIENT W/ ADDP ELIGIBILITY**	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.
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.	**2355**	**SENIOR GOLD RECIPENT W/ADDP ELIGIBILITY**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2356**	**MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS**	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.
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.	**2357**	**SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI**	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.
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.	**2360**	**OTC PREGNANCY TEST LIMIT - 1 PKG/CLAIM, 4 CLAIMS/30 DAYS**	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.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0405**	**POSSIBLE THERAPEUTIC CLASS DUPLICATION**		
18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0695**	**ADJUSTMENT / VOID ALREADY IN PROCESS**	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0795**	**CLAIM ADJUSTED BY SYSTEM - NEW ICN**	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.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0797**	**DUPLICATE ADJUSTMENT RECORDS ENTERED**	M58 (10/16/03)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0800**	**EXACT DUPLICATE BILL**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0801**	**POSSIBLE DUPLICATE CONFLICT**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0802**	**PHYSICIAN AND EPSDT DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0803**	**INPATIENT AND LTC DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0804**	**INPATIENT AND OUTPATIENT DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0807**	**INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0809**	**POSSIBLE DUPLICATE**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0810**	**DUPLICATE BILL - OVERLAPPING DATES OF SERVICES**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0812**	**TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR**	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0813**	**OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR**	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0814**	**PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0815**	**AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0816**	**CLINIC AND CLINIC CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0817**	**P&O AND P&O CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0818**	**DME AND DME CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0819**	**LAB AND LAB CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0820**	**OPTOMETRIST AND OPTOMETRIST CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0821**	**MID-LEVEL PRACT AND CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0822**	**EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0823**	**LTC AND LTC CROSSOVER DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0825**	**INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM**	N702 (01/29/16)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0827**	**PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER**	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.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0828**	**PHARMACY EXACT DUPLICATE BILL - DIFFERENT PROVIDER**		
18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0865**	**LTC AND HOSPICE DUPLICATE ERROR**	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0899**	**DUPLICATE ICN**	N702 (11/01/15)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0951**	**POSSIBLE DUPLICATE CCF - SEE RA MESSAGE #300**	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.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0954**	**CLAIM REPROCESSED TO CORRECT PAYMENTOR**	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.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**0956**	**CLAIM REPROCESSED TO CORRECT PAYMENT**	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.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1201**	**MULTIPLE HIST RECS FOUND FOR ADJ/VOID**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1607**	**FQHC DUPLICATE CONFLICT**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1622**	**CHARITY AND MEDICAID DUPLICATE ERROR**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1631**	**THERAPY CONFLICT WITH RESIDENTIAL, PARTIAL CARE, TRANSPORT**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1641**	**HOSPICE TRANSFER WITH MORE THAN ONE OVERLAPPING SERVICE DAY**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1642**	**HOSPICE XFER DAY OF DISCHARGE WITH > 1 OVERLAPPING SVC DAY**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (05/04/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1673**	**DEPT. OF CORRECTIONS/MEDICAID DUPLICATE ERROR**	N522 (05/04/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (12/04/17)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1676**	**DAILY/WEEKLY PSYCHOTHERAPY SERVICE LIMITS EXCEEDED**	N702 (12/04/17)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1812**	**CLAIM CHECK: PROCEDURE CODE IS MISSING**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**1813**	**CLAIM CHECK: DATE OF SERVICE REQUIRED FOR PROCEDURE**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**2118**	**THERAPEUTIC DUPLICATE FOUND USING NATIONAL STANDARD**		
18 (09/27/11)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**2142**	**GENERIC DRUG HAS NO PRICE - SUL/FUL/WAC/NADAC MISSING**	M86 (09/27/11)	Service denied because payment already made for same/similar procedure within set time frame.
22 (10/16/03)	This care may be covered by another payer per coordination of benefits.	**0393**	**PAAD/SR GOLD PAYMENT BASED ON PENDING MEDICARE ENROLLMENT**	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**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.	**0459**	**CLAIM PYMT ADJUSTED DUE TO OTHER INSURANCE.**		
22 (11/01/15)	This care may be covered by another payer per coordination of benefits.	**0511**	**OVERRIDE-USE PROVIDER MEDICARE PER DIEM RATE.**	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
22 (01/01/14)	This care may be covered by another payer per coordination of benefits.	**0637**	**MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**0959**	**CLAIM UPDATED WITH TPL PAYMENT**	N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**0973**	**CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE**	N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**0975**	**RESOURCE FILE INDICATES INSURANCE OTHER THAN THAT BILLED**	N245 (01/29/16)	Incomplete/invalid plan information for other insurance.
22 (01/15/24)	This care may be covered by another payer per coordination of benefits.	**1473**	**TPL EDITING BYPASSED - PAY AND CHASE CLAIM**	N883 (01/15/24)	Alert: Processed according to state law
22 (11/01/15)	This care may be covered by another payer per coordination of benefits.	**1646**	**HMS PRIVATE COVERAGE IS NOT PRESENT ON THE TPL**	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.
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**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.	**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.	**2043**	**RECIPIENT ELIGIBLE FOR MEDICARE PART D**		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**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.	**2130**	**HMS TPL CLAIM W/NO COB AMOUNTS**		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**2136**	**COB SEGMENT AND NO TPL PAID INFORMATION ON INPUT CLAIM**		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**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.	**2145**	**PART B COVERAGE KNOWN - BILL PART B/PART D/TPL**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**2146**	**COVERED BY ADDP HEALTH INSURANCE CONTINUATION (HIC) PROGRAM**		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**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.	**2229**	**MISSING QUALIFIER FOR OTHER PAYER AMOUNT PAID**		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	**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.	**2250**	**TPL PAYER ID REQUIRED WHEN BILLING FOR TPL COPAY/COINSURANCE**		
23 (01/01/14)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**0623**	**MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE**	N669 (05/01/16)	Adjusted based on the Medicare fee schedule.
23 (10/16/03)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**0625**	**MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**0882**	**ORTHODONTIC CUTBACK/INITIAL PAYMENT**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**0883**	**ORTHODONTIC CUTBACK/FINAL PAYMENT**	M85 (10/16/03)	Subjected to review of physician evaluation and management services.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**0300**	**HMO-COVERED SERVICE**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**0571**	**CAPITATION INDICATOR NOT MATCHED**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**0572**	**INVALID CAP CODE**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**0662**	**CLAIM PRICED-CHARGE TO MCAID AS PERCENT OF TOTAL CLM CHARGE**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**1021**	**CAPITATION PAYMENT REDUCED BY FULL PATIENT LIABILITY**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**1024**	**CAPITATION PAYMENT REDUCED BY PARTIAL PATIENT LIABILITY**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**1026**	**CAPITATION PAYMENT REDUCED FOR ELIGIBILITY LIMITS**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	**1380**	**GHI CROSSOVER - SERVICE IS IN-PLAN (MANAGED CARE)**	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
26 (11/01/15)	Expenses incurred prior to coverage.	**0110**	**DATE OF SERVICE < ADMISSION DATE**	N652 (11/01/15)	The date of service is before the date of loss.
26 (11/01/15)	Expenses incurred prior to coverage.	**0399**	**GA RECIPIENT ID CHANGED.**	N30 (11/01/15)	Patient ineligible for this service.
26 (11/01/15)	Expenses incurred prior to coverage.	**0521**	**RECIP NOT ON LTC MASTER FILE**	N30 (11/01/15)	Patient ineligible for this service.
26 (11/01/15)	Expenses incurred prior to coverage.	**0600**	**LTC RECIPIENT NOT ELIGIBLE ON DATE(S) OF SERVICE**	N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.
26 (01/01/14)	Expenses incurred prior to coverage.	**0613**	**DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE**	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.
26 (10/16/03)	Expenses incurred prior to coverage.	**0634**	**DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG PAYMENT DATE**	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
26 (10/16/03)	Expenses incurred prior to coverage.	**0635**	**LTC NEW ADMIT DATE OF SERVICE PRIOR TO ASSESSMENT DATE**	MA40 (10/16/03)	Missing/incomplete/invalid admission date.
27 (11/01/15)	Expenses incurred after coverage terminated.	**0222**	**LTC AGREEMENT TERMINATED:DISCHARGE PENDING FINAL DAY**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
27 (11/01/15)	Expenses incurred after coverage terminated.	**0525**	**LTC PASARR APPROVAL TERMINATED**	N30 (11/01/15)	Patient ineligible for this service.
27 (11/01/15)	Expenses incurred after coverage terminated.	**0528**	**LTC RECIP NOT ELIG FOR ENTIRE PERIOD-CUTBACK ASSESSMENT DTE**	N30 (11/01/15)	Patient ineligible for this service.
27 (01/01/14)	Expenses incurred after coverage terminated.	**0581**	**DENTAL SERVICES AFTER ELIGIBILITY TERMINATION**	N30 (01/01/14)	Patient ineligible for this service.
31 (11/01/15)	Patient cannot be identified as our insured.	**0368**	**NOT LOCK IN PHARMACY/EMERGENCY SUPPLY DISPENSED**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
31 (10/16/03)	Patient cannot be identified as our insured.	**0390**	**INVALID: REF PROV/ RCP CNTY/REF PROV TYP/PLC OF SVC FOR PROC**	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.
31 (10/16/03)	Patient cannot be identified as our insured.	**0394**	**MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD/SR GOLD PAYMENT**	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.
31 (11/01/15)	Patient cannot be identified as our insured.	**0398**	**GA RECIPIENT ID CHANGED TO MEDICAID RECIPIENT ID.**	MA61 (11/01/15)	Missing/incomplete/invalid social security number.
31 (10/16/03)	Patient cannot be identified as our insured.	**0952**	**CLAIM VOIDED - RECIPIENT ID ERROR**	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.
31 (01/01/16)	Patient cannot be identified as our insured.	**2108**	**CARDHOLDER ID INVALID**		
31 (01/29/16)	Patient cannot be identified as our insured.	**2178**	**INCORRECT PATIENT INFORMATION SUBMITTED**		
31 (01/29/16)	Patient cannot be identified as our insured.	**2230**	**INVALID PATIENT RESIDENCE CODE. MUST BE 00-15**		
31 (01/29/16)	Patient cannot be identified as our insured.	**2278**	**CARDHOLDER ID ON PARTD VOID IS INVALID**		
32 (01/01/16)	Our records indicate the patient is not an eligible dependent.	**2023**	**BENEFICIARY INELIGIBLE FOR PART D ON DOS**		
32 (01/01/16)	Our records indicate the patient is not an eligible dependent.	**2036**	**RECIPIENT NOT ELIGIBLE FOR MAILORDER SERVICES**		
35 (01/01/14)	Lifetime benefit maximum has been reached.	**0601**	**PAYMENT REDUCED TO MEDICAID MAXIMUM**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
39 (01/01/16)	Services denied at the time authorization/pre-certification was requested.	**2000**	**SERVICE ADMINISTRATIVELY DENIED**		
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.	**0605**	**OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING**	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0608**	**PEND FOR MANUAL PRICING**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
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)	**0630**	**LTC LEAVE DAYS CUT BACK TO MAXIMUM ALLOWED**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1288**	**INVALID/MISSING UB04 ADMIT DIAGNOSIS**	MA65 (11/01/15)	Missing/incomplete/invalid admitting diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1289**	**UB04 ADMIT DIAGNOSIS NOT ON FILE**	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1291**	**INVALID UB04 PATIENT REASON FOR VISIT**	M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1292**	**UB04 PATIENT REASON FOR VISIT NOT ON FILE**	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1293**	**INVALID UB04 EXTERNAL INJURY CODE**	M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**1294**	**UB04 EXTERNAL INJURY CODE NOT ON FILE**	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
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.	**0752**	**VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM**	N429 (01/01/14)	Not covered when considered routine.
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.	**0753**	**SURGERY/VISIT CONFLICT**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0524**	**INVALID LTC PSYCH RECIPIENT AGE**	N129 (11/01/15)	Not eligible due to the patient's age.
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.	**1426**	**EARLY ELECTIVE DELIVERY**	N661 (08/02/20)	Documentation does not support that the services rendered were medically necessary.
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.	**1469**	**EARLY ELECTIVE DELIVERY DENIAL OVERRIDDEN**	N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.
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.	**1804**	**CLAIM CHECK: COSMETIC PROCEDURE**	N383 (01/01/14)	Not covered when deemed cosmetic.
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.	**1807**	**CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED**	N383 (01/01/14)	Not covered when deemed cosmetic.
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.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1603**	**ADJ/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIG**	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
52 (01/01/13)	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	**1386**	**PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - BILLING**	N95 (02/01/16)	This provider type/provider specialty may not bill this service.
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.	**0234**	**PEND FOR OUT-OF-STATE NON-DRG PRICING POLICY CHANGE**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
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.	**0458**	**OCCURRENCE CODE INDICATES ACCIDENT REVIEW REQUIRED**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
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.	**1810**	**CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL**	M49 (01/01/14)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**2249**	**GERIATRIC PRECAUTION FOUND-DRUG IS ON BEERS/HEDIS/STOPP LIST**		
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.	**1300**	**MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY**	M123 (01/01/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
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.	**0236**	**PROCEDURE/PLACE OF SERVICE RESTRICTION**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1007**	**SUD PLACE OF SERVICE RESTRICTION**	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.
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.	**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.	**2247**	**FACILITY ID IS MISSING OR INVALID**		
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.	**0759**	**PAYMENT REDUCED - SURGERY/ANESTHESIA CONFLICT**	N633 (01/01/14)	Additional anesthesia time units are not allowed.
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.	**0901**	**MULTIPLE SURGERY-PAID AS PRIMARY PROCEDURE**	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.
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.	**0902**	**MULTIPLE SURGERY-PAID AS SECONDARY PROC, MAX 200% OF PRIMARY**	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.
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.	**0903**	**MULT SURG - PRIME PROC FEE REDUCED BY PRIOR PAID CLAIM**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0904**	**MULTIPLE SURGERY-$0 PAID, LIMIT EXCEEDED**	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.
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.	**0907**	**MULT SURG- 1ST UNIT PRIMARY, ADDT'L AS SECONDARY - 200% MAX**	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.
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.	**2134**	**PSYCHOTROPIC DRUGS-FIVE OR MORE USED CONCURRENTLY**		
62 (10/16/03)	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	**0937**	**PRIOR AUTHORIZED UNITS USED FOR CLAIM PAYMENT**	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.	**0844**	**ADJUSTMENT CLAIM MISSING PAYOR CODE AND/OR PRIOR PAYMENT**	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.	**0846**	**ADJUSTMENT MUST HAVE RA ATTACHED**	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
92 (05/02/11)	Claim Paid in full.	**1301**	**MAXIMUM DAILY DOSAGE NOT FOUND**	M123 (05/02/11)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
92 (06/01/10)	Claim Paid in full.	**1608**	**INITIAL DETERMINATION OF PURCHASE**	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.
95 (02/01/16)	Plan procedures not followed.	**0197**	**MISSING/INVALID NCPDP MAND**		
95 (01/03/16)	Plan procedures not followed.	**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.	**0478**	**NO LONGER ACCEPT PAPER COMPOUND CLAIMS**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
95 (02/01/16)	Plan procedures not followed.	**0512**	**DRUG NOT PAYABLE - NO ADDP REBATE AGREEMENT**		
95 (01/29/16)	Plan procedures not followed.	**0879**	**MEDICARE / PAAD ADJUSTMENT**		
95 (01/29/16)	Plan procedures not followed.	**0880**	**CUMULATIVE RETRO REVIEW - FOR INTERNAL USE.**		
95 (11/28/16)	Plan procedures not followed.	**1448**	**SERVICE NOT RELATED TO TERMINAL COND FOR HOSPICE BENEFICIARY**	N629 (11/28/16)	Reviews/documentation/notes/summaries/reports/charts not requested.
95 (10/20/14)	Plan procedures not followed.	**1618**	**MEDICARE PART A REQUIRED FOR MN HOSPICE SERVICES**	M79 (10/20/14)	Missing/incomplete/invalid charge.
95 (01/01/16)	Plan procedures not followed.	**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.	**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.	**2029**	**PART D PAPER CLAIM NOT ALLOWED FOR PART D COB CLAIMS**		
95 (01/29/16)	Plan procedures not followed.	**2115**	**AWP WITH PRE-SETTLEMENT FORMULA LESS THAN AWP ON FILE**		
95 (01/29/16)	Plan procedures not followed.	**2122**	**PARTD DEDUCTIBLE INVALID FOR TITLE XIX BENEFICIARY**		
95 (01/29/16)	Plan procedures not followed.	**2127**	**HMS AUDIT B1 REPLACEMENT CLAIM, ORIG CLM NOT AUDITED BY HMS**		
95 (01/29/16)	Plan procedures not followed.	**2129**	**HMS AUDIT ADJUSTMENT REASON 42/47 ADDED TO POS HISTORY CLAIM**		
95 (01/29/16)	Plan procedures not followed.	**2226**	**INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0009**	**SERVICES NOT COVERED FOR THIS RECIPIENT.**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**0116**	**INVALID LEAVE OF ABSENCE DATE**	N43 (10/16/03)	Bed hold or leave days exceeded.
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.	**0117**	**LEAVE OF ABSENCE DATE(S) OUTSIDE DATES OF SERVICE**	N43 (10/16/03)	Bed hold or leave days exceeded.
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.	**0118**	**LEAVE OF ABSENCE FROM/THRU DATE CONFLICT**	N43 (10/16/03)	Bed hold or leave days exceeded.
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.	**0121**	**MCARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE**	N43 (10/16/03)	Bed hold or leave days exceeded.
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.	**0122**	**MCARE BED HOLD END DATE OUTSIDE DATES OF SERVICE**	N43 (10/16/03)	Bed hold or leave days exceeded.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0126**	**COMPOUND DRUG INDICATOR INVALID**	N163 (11/01/15)	Medical record does not support code billed per the code definition.
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.	**0223**	**PROVIDER ON REVIEW-DENY PAYMENT**	N35 (11/01/15)	Program integrity/utilization review decision.
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.	**0263**	**NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE**	N30 (10/16/03)	Patient ineligible for this 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.	**0266**	**NOT AN SAI COVERED SERVICE**	N95 (10/16/03)	This provider type/provider specialty may not bill this 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.	**0270**	**ROUTINE IMMUNIZATION FOR HEPTITIS "A" IS NON-COVERED SERVICE**	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.
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.	**0279**	**DENIED AS A RESULT OF PREPAYMENT REVIEW BY DMAHS**	M87 (10/16/03)	Claim/service(s) subjected to CFO-CAP prepayment review.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0280**	**POS PAID CLAIM, PAYMENT PENDING**	N35 (11/01/15)	Program integrity/utilization review decision.
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.	**0285**	**HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE**	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.
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.	**0301**	**RECIPIENT INELIG ON DATES OF SERVICE**	N30 (10/16/03)	Patient ineligible for this service.
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.	**0304**	**PRESUMPTIVELY ELIGIBLE RECIPIENT (NON-COVERED)**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**0305**	**CCPED OR HCEP NON COVERED SERVICE**	N30 (01/01/14)	Patient ineligible for this service.
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.	**0308**	**INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM**	N30 (09/01/20)	Patient ineligible for this service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0309**	**GSHP OUT-OF-PLAN SERVICE- RECIPIENT INELIGIBLE FOR MEDICAID**	N30 (01/01/14)	Patient ineligible for this 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.	**0315**	**HOSPICE ELECTION REVIEW**	N35 (10/16/03)	Program integrity/utilization review decision.
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.	**0316**	**LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE**	N35 (11/01/15)	Program integrity/utilization review decision.
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.	**0350**	**GENERAL ASSISTANCE-SERVICE NOT COVERED.**	N30 (10/16/03)	Patient ineligible for this 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.	**0358**	**SECOND OPINION - DATE RESTRICTION**	N129 (11/01/15)	Not eligible due to the patient's age.
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.	**0359**	**SECOND OPINION DATE AND AGE RESTRICTION**	N129 (11/01/15)	Not eligible due to the patient's age.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0365**	**GA RECIPIENT NOT ON RECIP HISTORY MASTER FILE**	N30 (10/16/03)	Patient ineligible for this 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.	**0370**	**PLAN H - BENEFICIARY - NON-COVERED SERVICE.**	N30 (11/03/03)	Patient ineligible for this 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.	**0371**	**CSOCI - UNABLE TO DETERMINE COVERAGE**	N30 (11/01/15)	Patient ineligible for this 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.	**0373**	**CSOCI - NON-COVERED SERVICE**	N30 (10/16/03)	Patient ineligible for this 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.	**0375**	**SPECIAL STATE AUTO PEND**	N35 (10/16/03)	Program integrity/utilization review decision.
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.	**0379**	**SPEC PGM UNABLE TO DETERMINE COVERAGE**	N35 (10/16/03)	Program integrity/utilization review decision.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0385**	**NON-COVERED SERVICE FOR PROGRAM STATUS CODE**	N30 (10/16/03)	Patient ineligible for this 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.	**0424**	**ELIG ENDED BEFORE CLAIM THRU DATE FOR DME-CUTBACK APPLIED**	N622 (11/01/15)	Not covered based on the date of injury/accident.
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.	**0426**	**NO FQHC ENCOUNTER WITH DELIVERY HCPCS CLAIM PAID AT NON-ZERO**	N35 (11/01/15)	Program integrity/utilization review decision.
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.	**0432**	**THIS LEGEND DRUG NOT COVERED BY PAAD/SG**	N30 (10/16/03)	Patient ineligible for this 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.	**0450**	**DRUG NOT COVERED FOR ESRD RECIPIENT**	N30 (10/16/03)	Patient ineligible for this 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.	**0451**	**MEDICAL SUPPLY OR SERVICE(S) NOT COVERED FOR ESRD RECIPIENT**	N30 (10/16/03)	Patient ineligible for this service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0455**	**RECIPIENT NOT ELIGIBLE ON FROM D.O.S. NO DEDUCTIBLE DUE**	N408 (11/01/15)	This payer does not cover deductibles assessed by a previous payer.
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.	**0456**	**LAB NOT COVERED FOR ESRD RECIPIENT**	N30 (10/16/03)	Patient ineligible for this 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.	**0509**	**MEDICARE BED HOLD INVALID**	N43 (11/01/15)	Bed hold or leave days exceeded.
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.	**0532**	**NON LEGEND DRUG NOT COVERED FOR PAAD/SR GOLD BENEFICIARIES**	N30 (10/16/03)	Patient ineligible for this 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.	**0534**	**DRUG NOT PAYABLE FEDERAL/IRS DESI**	N30 (10/16/03)	Patient ineligible for this 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.	**0552**	**ADDP-SERVICE NOT COVERED.**	N30 (10/16/03)	Patient ineligible for this service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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 (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.	**0561**	**COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT**	N30 (10/16/03)	Patient ineligible for this 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.	**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 (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.	**0573**	**CAPITATION RATE NOT ON FILE**	N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0629**	**PATIENT LIABILITY CONFLICT - PAYMENT REDUCED**	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'.
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.	**0667**	**COMPUTED DRUG COST ALLOW IS ZERO - VERIFY/CORRECT QUANTITY**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0698**	**COINSURANCE DAYS EXCEED MEDICARE MAXIMUM OF 30 DAYS**	N58 (09/01/20)	Missing/incomplete/invalid patient liability amount.
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.	**0699**	**LIFETIME RESERVE DAYS EXCEED MEDICARE MAXIMUM OF 60 DAYS**	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable 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.	**0700**	**CONFLICTING SAME DAY LAB SERVICE**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**0712**	**CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM-DENY**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0716**	**PROCEDURE INCLUDED IN THE PHYSICIAN VISIT**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**0718**	**HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT**	N43 (01/01/14)	Bed hold or leave days exceeded.
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.	**0719**	**THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT**	N43 (01/01/14)	Bed hold or leave days exceeded.
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.	**0724**	**DATE(S) OF SERVICE DO NOT MATCH LAB PANEL PROCEDURE EFF DATE**	N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
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.	**0730**	**SPECIMEN COLLECTION GREATER THAN ONE**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**0735**	**INITIAL VISIT/ANNUAL EXAM/EPSDT EXAM LIMIT**	N666 (01/01/14)	Only one evaluation and management code at this service level is covered during the course of care.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0739**	**TRANSPORT CLAIM MUST PAY FIRST**	N157 (01/01/14)	Transportation to/from this destination is 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.	**0747**	**PROPHYLAXIS LIMIT**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
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.	**0790**	**INVALID ADJUSTMENT LOCATOR**	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
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.	**0833**	**CLAIM FOR CONTINUOUS LEAVE- NO PRIOR SERVICE DATE PAID CLAIM**	N43 (01/01/16)	Bed hold or leave days exceeded.
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.	**0884**	**CLAIM DENIED/SUBMIT DME CLAIM TO MEDICARE**	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.
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.	**0900**	**ZERO PAYMENT - INFORMATIONAL EPSDT CLAIM ONLY**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0925**	**UTILIZATION REVIEW APPROVAL MISSING/INCORRECT/DENIED**	N35 (01/01/14)	Program integrity/utilization review decision.
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.	**0930**	**BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS**	N43 (01/01/14)	Bed hold or leave days exceeded.
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.	**0932**	**THERAPEUTIC LEAVE EXCEEDS MAXIMUM OF 24 CONSECUTIVE DAYS**	N43 (01/01/14)	Bed hold or leave days exceeded.
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.	**0933**	**THERAPEUTIC LEAVE CUTBACK TO 24 DAYS MAXIMUM**	N43 (11/01/15)	Bed hold or leave days exceeded.
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.	**0934**	**BED-HOLD CUTBACK TO 10 DAY MAXIMUM**	N43 (01/01/14)	Bed hold or leave days exceeded.
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.	**0936**	**INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0939**	**RECIPIENT IS MEDICARE PART A ELIGIBLE**	M28 (10/16/03)	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
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.	**0945**	**'CARE ASSIGNMENT NOT ACCEPTED - CLAIM NOT PAYABLE BY 'CAID**	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.
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.	**0953**	**CLAIM VOIDED - SERVICE BILLED INCORRECTLY**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**0958**	**DENIED ACCORDING TO MEDICAID/MEDICAL REVIEW GUIDELINES**	N109 (08/01/15)	Alert: This claim/service was chosen for complex review.
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.	**0962**	**ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND**	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.
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.	**0963**	**RECIPIENT HAS MEDICARE - BILL MEDICARE**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0970**	**BILL THIRD PARTY CARRIER OR MEDICARE HMO FIRST**	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.
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.	**0979**	**RECIPIENT IS MCARE PART B OR MCARE HMO ELIGIBLE**	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.
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.	**1038**	**PROVIDER NOT COVERED FOR OORP SERVICES**	N9 (11/29/21)	Adjustment represents the estimated amount a previous payer may pay.
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.	**1248**	**NO BED HOLD/THERAPEUTIC LEAVE PAYMT FOR NURSING FACILITY**	N43 (07/01/07)	Bed hold or leave days exceeded.
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.	**1337**	**ASC PROCEDURE SERVICE**	N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
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.	**1388**	**MEDICARE HMO DEDUCTIBLE EXCEEDS YEARLY MAXIMUM**	N408 (02/01/16)	This payer does not cover deductibles assessed by a previous payer.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1447**	**RECIPIENT INELIGIBLE FOR CSOC RESPITE SERVICE**	N30 (05/15/17)	Patient ineligible for this service.
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.	**1453**	**INCORRECTLY BILLED SVC; REQUIRES HH MOD, CCBHC SVC/PROV**	N95 (06/26/17)	This provider type/provider specialty may not bill this 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.	**1600**	**CLAIM EXCEEDS BEDS LICENSED TO PROVIDER FOR THE MONTH**	N54 (01/01/14)	Claim information is inconsistent with pre-certified/authorized services.
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.	**1609**	**LONG TERM PSYCHIATRIC CLAIM REDUCED BY PR1**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**1614**	**OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**1624**	**PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY**	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'.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1627**	**EXHAUSTED CHARGES A3 AMOUNT REPORTED ON THE CLAIM**	N587 (11/01/15)	Policy benefits have been exhausted.
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.	**1632**	**PROVIDER ADULT MDC UNIT EXCEEDS 200 UNIT PER DAY**	M139 (01/01/14)	Denied services exceed the coverage limit for the demonstration.
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.	**1670**	**NUMBER OF UNITS EXCEEDS 6 IN A 14 DAY PERIOD**	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
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.	**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.	**2035**	**INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**2151**	**RX IS A COMPOUND, NOT BILLED AS A COMPOUND**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2323**	**DAILY MORPHINE MILLIGRAM EQUIVALENT > 50**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**2324**	**DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0392**	**PROCEDURE CODE MAPPED TO LOCAL CODE FOR PROCESSING PURPOSES**	N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
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.	**0427**	**FQHC DELIVERY HCPCS MINUS ENCOUNTER RATE.**	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.
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.	**0483**	**LAB TEST INCLUDED IN ESRD COMPOSITE RATE**	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.
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.	**0664**	**ITEM BILLED IS INCLUDED IN ADMINSTRATION/SUPPLY KIT**	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.
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.	**0670**	**NO PAYMENT DUE-MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWABLE**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0703**	**EPISIOTOMY INCLUDED IN DELIVERY CHARGE**	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.
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.	**0713**	**LAB TEST CONFLICT/LAB PANEL PROCEDURE PREVIOUSLY PAID**	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.
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.	**0714**	**LAB TEST CONFLICT, INDIVIDUAL TEST(S) PREVIOUSLY PAID**	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.
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.	**0729**	**CLAIM PAYMENT REDUCED FOR PREVIOUSLY PAID VISIT**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**0741**	**PROCEDURE DENIED - COMPONENT PREVIOUSLY PD CLAIM**	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.
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.	**0745**	**HOSPITAL CALL/CONSULTATION CONFLICT**	N637 (01/01/14)	Consultations are not allowed once treatment has been rendered by the same provider.
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.	**0805**	**INPATIENT AND HOME HEALTH DUPLICATE ERROR**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0806**	**LTC AND HOME HEALTH DUPLICATE ERROR**	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.
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.	**0840**	**EXACT DUPLICATE WITHIN GROUP PRACTICE**	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.
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.	**0906**	**MULTIPLE SURGERY - $0 PAID, INCIDENTAL PROCEDURE**	N19 (01/01/14)	Procedure code incidental to primary procedure.
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.	**0950**	**RE-PROCESSED PREVIOUSLY DENIED CLAIM**	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.
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.	**0964**	**ADJUSTMENT OR VOID CORRESPONDS TO CANCELLED MMIS CHECK**	N432 (01/29/16)	Alert: Adjustment based on a Recovery Audit.
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.	**0968**	**PROCEDURE CODE DOES NOT ACCURATELY REFLECT SERVICES RENDERED**	N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
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.	**1348**	**HMS AUDIT - ADJUSTMENT/VOID REQUEST DENIED**	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1367**	**HMS COMMERCIAL TPL RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1368**	**HMS COMMERCIAL TPL RECOVERY-PROVIDER ADJUSTMENTS ALLOWED**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1369**	**HMS CREDIT BALANCE RECOVERY - EXCESS PAY**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1370**	**HMS CREDIT BALANCE RECOVERY - READMISSION**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1371**	**HMS CREDIT BALANCE RECOVERY - TRANSFER**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1372**	**HMS CREDIT BALANCE RECOVERY - DUPLICATE PAYMENT**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**1373**	**HMS MEDICARE RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1374**	**HMS MEDICARE RECOVERY - PROVIDER ADJUSTMENTS ALLOWED**	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
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.	**1376**	**HMS RAC RECOVERY - NO FURTHER PROVIDER ADJUSTMENTS**	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
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.	**1377**	**HMS RAC RECOVERY PROVIDER ADJUSTMENTS ALLOWED**	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
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.	**1615**	**CUTBACK-OBSERVATION OFFICE VISIT ALREADY PAID**	M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.
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.	**1815**	**CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**1818**	**CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**	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.
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.	**1878**	**CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1890**	**CLAIM CHECK: POST OPERATIVE PROCEDURE CODE**	M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/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.	**1891**	**CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE**	M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/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.	**1892**	**CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**	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.
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.	**1895**	**CLAIM CHECK: DUPLICATE PROCEDURE**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
106 (10/16/03)	Patient payment option/election not in effect.	**0531**	**LTC/HOSPICE REQUIRES PR-1 OR LTC REQUIRES PATIENT PYT AMOUNT**	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.
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.	**0533**	**OTC DRUG COST INCLUDED IN NF PER DIEM**	N65 (04/01/18)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0564**	**NO VOLUME DISCOUNT ON FILE FOR CLAIM SERVICE DATE**	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
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.	**0565**	**OTC DRUG NO UNIT PRICE ON FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0566**	**OTC DRUG NO PACKAGE PRICE ON FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0567**	**TEAMCARE DRUG NO UNIT PRICE ON FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0568**	**TEAMCARE DRUG NO PACKAGE PRICE ON FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0569**	**LEGEND DRUG NO PACKAGE PRICE ON FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**0666**	**UNABLE TO PRICE CLAIM**	MA66 (11/01/15)	Missing/incomplete/invalid principal procedure code.
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.	**0785**	**MAINFRAME CLAIM NOT PRESENT ON POS HISTORY**		
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.	**0849**	**RENTAL DENIED/PRIOR PURCHASE WITHIN 24 MONTHS**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0851**	**DME RENTAL LIMIT 6 IN 24 MONTHS EXCEEDED**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0852**	**DME RENTAL LIMIT 10 IN 24 MONTHS EXCEEDED**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0853**	**PURCHASE DENIED/6 PRIOR RENTALS WITHIN 24 MONTHS**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0854**	**PURCHASE DENIED/10 PRIOR RENTALS IN 24 MONTHS**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
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.	**0855**	**PURCHASE DENIED/PRIOR PURCHASE WITHIN 24 MONTHS**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0391**	**PREMIUM SUPPORT - BILL OTHER INSURANCE**	N36 (11/01/15)	Claim must meet primary payer's processing requirements before we can consider payment.
109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0400**	**NOT VALID CAPITATION CLAIM**	N418 (11/01/15)	Misrouted claim. See the payer's claim submission instructions.
109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0402**	**NOT COVERED BY GA - BILL ADDP**		
109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**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 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0484**	**ESRD POSSIBLY ELIGIBLE FOR MEDICARE**	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.
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0645**	**MISSING NEW YORK EXEMPT FACILITY RATE DATE**	N538 (11/01/15)	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**0682**	**SERVICE/PRODUCT NOT ELIGIBLE UNDER MEDICAID PROGRAM**	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.
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**1006**	**CLAIM IS 100% MEDICARE-COVERED - NO MEDICAID PAYMENT DUE**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**1836**	**CLAIM CHECK: CLAIM WAS BYPASSED**	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.
109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**1899**	**CLAIM CHECK: BYPASS CLAIM CHECK**	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.
109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**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.	**2236**	**PARTD PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED**		
110 (01/01/14)	Billing date predates service date.	**0021**	**BILLED DATE LESS THAN THRU DATE**	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	**0023**	**BILLED DATE < STATEMENT THRU DATE**	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	**0490**	**INPATIENT DATE OF SURGERY < SERVICE FROM DATE**	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	**0529**	**CLAIM DATES OF SERVICE BEFORE INITIAL ASSESSMENT DATE**	N622 (01/01/14)	Not covered based on the date of injury/accident.
114 (01/01/16)	Procedure/product not approved by the Food and Drug Administration.	**2119**	**NON-COVERED NDC PER CMS/FDA RESTRICTION**		
117 (10/16/03)	Transportation is only covered to the closest facility that can provide the necessary care.	**0633**	**AMBULANCE/INVALID COACH < 16 MILES**	M69 (10/16/03)	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0148**	**RESPITE CARE EXCEEDS MAXIMUM OF 5 DAYS**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0276**	**UTILIZATION EXCEEDS ESTABLISHED PARAMETERS**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0289**	**PAYMENT BASED ON THE PLACE OF SERVICE**	N45 (11/01/15)	Payment based on authorized amount.
119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.	**0403**	**DURATION AT THIS DOSAGE EXCEEDED**	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**0526**	**PA-3L INCOME GREATER THAN PATIENT PAYMENT AMOUNT PA-3L USED**	N45 (10/16/03)	Payment based on authorized amount.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**0610**	**MANUAL PRICING EXCEEDS BILLED CHARGES**	M139 (01/01/16)	Denied services exceed the coverage limit for the demonstration.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0672**	**SPLIT CLAIM RECIP ELIG ON DISCHARGE DATE ONLY-NO PMT DUE**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0673**	**SPLIT CLAIM ALL ELIG DAYS ARE RESIDENTIAL-NO PAYMENT DUE**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0674**	**SPLIT CLAIM SNF/ICF DAYS AT/BELOW DRG HIGH TRIM-NO PMT DUE**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0675**	**SPLIT CLAIM NJ HIV OUTLIER CLAIM-SNF/ICF DAYS NOT PAYABLE**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0701**	**DUPLICATE CONSULTATION**	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.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0702**	**SERVICE CONFLICTS WITH SIMILAR SAME DAY PROCEDURE**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0705**	**CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0706**	**30 DAY NEONATAL CARE LIMIT**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0707**	**60 DAY NEONATAL CARE LIMITATION**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0715**	**MENTAL HEALTH SERVICES OVER $400-NF/BOARDING HOME**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0717**	**PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED**	N587 (11/01/15)	Policy benefits have been exhausted.
119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.	**0720**	**TARGETED CASE MANAGEMENT LIMIT EXCEEDED**	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0721**	**CONFLICTING TARGETED CASE MANAGEMENT SERVICE**	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0731**	**THREE YEAR XRAY LIMITATION EXCEEDED**	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0733**	**CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0734**	**SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0736**	**LAB SERVICE**	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0737**	**PAAD/SR GOLD RECIP REFILL > 12 MO FROM ORIGINAL PRESCRIPTION**	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0738**	**REFILL EXCEEDS PROGRAM MAXIMUM**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0740**	**OPT APP EXCEEDS PROGRAM LIMITATION**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0748**	**ORAL EXAMINATION LIMIT**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	**0755**	**EARLY REFILL**	M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	**0757**	**DRUG SUPPLIED EARLY BY DIFFERENT PROVIDERS**	M80 (10/16/03)	Not covered when performed during the same session/date as a previously processed service for the patient.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0760**	**NORPLANT EXCEED 2 IN 5 YEARS - SAME PROVIDER**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0761**	**NORPLANT EXCEEDS 2 IN 5 YEARS - DIFFERENT PROVIDER**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0762**	**MENTAL HEALTH SERVICES EXCEED $900**	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0764**	**PARTIAL CARE AND FULL DAY NOT PAYABLE ON SAME DAY**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0765**	**DELIVERY/ABORTION PROCEDURE LIMITS**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0766**	**WAIVER SERVICE CONFLICT**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0767**	**PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0834**	**TBI COUNSELING EXCEEDS $600/MNTH**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0835**	**TBI TRANSPORTATION EXCEEDS $100/WK**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0836**	**TBI ENVIRONMENTAL MOD EXCEEDS $5000/MNTH**	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0837**	**TBI BEHAVIOR PROGRAM EXCEEDS UNITS OF SERVICE**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0857**	**WEEKLY PERSONAL CARE ASSISTANCE/MENTAL HEALTH HRS EXCEED 25**	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0858**	**WEEKLY PERSONAL CARE ASSISTANT (PCA) SVCS HOURS EXCEED 40**	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0859**	**CLAIM OVERLAPS CALENDAR WORK WEEK-SUN.12:00AM TO SAT.11:59PM**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	**0872**	**FAMILYCARE THERAPY SERVICE LIMITS**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0873**	**KIDCARE D MENTAL HEALTH SERVICE FOR BENEFIT YEAR EXCEEDED**	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**0875**	**FISCAL YEAR FUNDS EXHAUSTED**	N587 (01/01/14)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**0910**	**PAYMENT EXCEEDS THRESHOLD**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	**0918**	**DAILY DOSAGE EXCEEDS MAXIMUM RECOMMENDED DOSAGE**	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.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	**0938**	**VOIDED CLAIM EXCEEDS PROGRAM LIMITS**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.	**0990**	**DELAYED PAYMENT OF PROPRIETARY ELECTRONIC CLAIM**	N381 (01/29/16)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1012**	**VALUE OF ONE OR MORE OF THESE FIELDS WAS > MAX ALLOWED**	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.	**1014**	**DDD SELF DIRECTED INSUFFICIENT PA FUNDING TO FULFILL CLAIM**	N587 (04/01/18)	Policy benefits have been exhausted.
119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.	**1015**	**DDD/IME CLAIM MODIFIERS DO NOT MATCH PA MODIFIERS**	N587 (04/02/18)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1207**	**PAYMENT PENDING SFY JULY 1 APPROPRIATION**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1210**	**PART A EXHAUSTED CHARGES IS GREATER THAN 99,999,99**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1255**	**MEDICARE SUP CLAIM W/O EXHAUSTED DATE OR CHARGES**	N587 (11/01/15)	Policy benefits have been exhausted.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1256**	**MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY**	N587 (11/01/15)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1257**	**MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY**	N587 (11/01/15)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1335**	**PAYMENT REDUCED TO SUL PRICE**	N45 (11/01/15)	Payment based on authorized amount.
119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.	**1606**	**RATE DECREASE WHEN PARTIAL HOSPITALIZATION EXCEEDS 24 MONTH**	N362 (01/29/16)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**1623**	**OUTPATIENT ACUTE ADULT PARTIAL HOSPITALIZATION TIME EXCEEDED**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**1630**	**MCARE LTC CLAIM WITH OVERLAPPING DOS**	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
119 (06/01/14)	Benefit maximum for this time period or occurrence has been reached.	**1649**	**OP TRANS PMT REDUCED BY PREVIOUS PAID OP TRANS CLM**	N362 (06/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	**1652**	**MENTAL HEALTH CLAIM CUTBACK - BENEFIT LIMIT REACHED**	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/21)	Benefit maximum for this time period or occurrence has been reached.	**1702**	**DOULA VISITS EXCEED LIMIT**	N435 (01/01/21)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (07/01/22)	Benefit maximum for this time period or occurrence has been reached.	**1711**	**SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES**	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.
119 (11/22/22)	Benefit maximum for this time period or occurrence has been reached.	**1713**	**DIABETES SERVICES EXCEED LIMIT**	M53 (11/22/22)	Missing/incomplete/invalid days or units of service.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**1805**	**CLAIM CHECK: CLAIM LINES EXCEED MAXIMUM**	N362 (01/01/16)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	**1858**	**CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM**	N640 (01/01/16)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**2028**	**CLAIM PAYMENT THRESHOLD EXCEEDS $25000 / 125000**		
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**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.	**2040**	**MEDICARE PART D CO-PAYMENT EXCEEDS MAX ALLOWED.**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	**2042**	**COPAY EXCEEDS CHARGE FOR 3 MONTH SUPPLY FOR RECIP LIS LEVEL**		
119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.	**2297**	**CLAIM SUBMITTED AS A 340B CLAIM**	N45 (04/01/17)	Payment based on authorized amount.
128 (01/01/16)	Newborn's services are covered in the mother's Allowance.	**1239**	**MOTHER OF NEWBORN HAS SERVICE IN-PLAN**		
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.)	**0476**	**NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**	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.
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.)	**0488**	**DRG INTERIM BILL APPROVAL REQUIRED**	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.
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.)	**0516**	**EPSDT FFS INCENTIVE PAYMENT ERROR**	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.
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.)	**0517**	**PASARR RECORD MISSING**	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.
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.)	**0518**	**INVALID PASARR DATA**	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.
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.)	**0787**	**ADJUSTMENT CLAIM TYPE NOT MATCHED**	N48 (01/01/14)	Claim information does not agree with information received from other insurance carrier.
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.)	**0794**	**FINANCIAL CORRECTION REQUIRED**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.)	**0798**	**HISTORY RECORD ALREADY ADJUSTED OR VOIDED**	N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.
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.)	**0869**	**POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT**	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.
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.)	**1205**	**ADJUSTMENT/VOID DOES NOT MATCH RECIPIENT ID ON CLAIM**	MA36 (01/01/14)	Missing/incomplete/invalid patient name.
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.)	**1249**	**MISSING PRIMARY PAYER IDENTIFICATION**	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.
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.)	**1250**	**MISSING SECONDARY PAYER IDENTIFICATION**	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.
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.)	**1251**	**MISSING TERTIARY PAYER IDENTIFICATION**	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.
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.)	**1253**	**SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT**	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.
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.)	**1254**	**INVALID PRIMARY BENEFITS EXHAUST DATE**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.)	**1466**	**REPROCESSED AT THE REQUEST OF MFD - WITHOUT A UD MODIFIER**	MA67 (05/04/21)	Alert: Correction to a prior claim.
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.)	**1470**	**RECYCLED AFTER CHANGE OF OWNERSHIP - ALM 3708**	MA67 (03/20/23)	Alert: Correction to a prior claim.
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.)	**1688**	**CLM FOR REQUIRED BASE TIME CODE NOT RECEIVED FOR ADD ON CODE**	N702 (07/01/20)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
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.)	**1752**	**NO PRESUMPTIVE DRUG TEST WITHIN 7 DAYS**	N702 (01/01/21)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
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).	**0541**	**COMPOUND DRUG MANUAL REVIEW REQUIRED**	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for 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).	**0550**	**PENDING FOR REVIEW OF DRUG FILE ENTRY**	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer 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).	**0563**	**NO BASE DISPENSING FEE ON FILE FOR CLAIM SERVICE DATE**	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for 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).	**0603**	**PROVIDER NOT ON DRG RATE FILE**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0617**	**CALCULATED PAYMENT AMOUNT ZERO**	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer 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).	**0651**	**MISSING PENNSYLVANNIA DRG RATE DATA**	N35 (10/16/03)	Program integrity/utilization review decision.
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).	**0652**	**MISSING NEW YORK DRG RATE DATA**	N35 (10/16/03)	Program integrity/utilization review decision.
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).	**0653**	**MISSING NY DRG SERVICE INTENSITY WEIGHT**	N35 (10/16/03)	Program integrity/utilization review decision.
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).	**0654**	**MISSING NY DRG OUTLIER PERCENT**	N35 (10/16/03)	Program integrity/utilization review decision.
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).	**0655**	**MISSING NEW YORK DRG ALC PER DIEM RATE**	N35 (10/16/03)	Program integrity/utilization review decision.
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).	**0656**	**MISSING NJ DRG MARKUP FACTOR**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0992**	**SET LOCATION TO STATE REVIEW**	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for 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).	**0996**	**NO APPROP CODES ASSIGNED FOR CREDIT RECORD**	N29 (10/16/03)	Missing documentation/orders/notes/summary/report/chart.
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).	**1333**	**PLEASE CONTACT THE MANAGE CARE OFFICE AT 1-800-701-0710**	MA07 (11/08/10)	Alert: The claim information has also been forwarded to Medicaid for review.
140 (01/01/16)	Patient/Insured health identification number and name do not match.	**2128**	**6-DIGIT ICN ON HMS AUDIT CLAIM DOES NOT MATCH NJMMIS CLAIM**		
141 (01/01/14)	Claim spans eligible and ineligible periods of coverage.	**0620**	**RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
146 (11/01/15)	Diagnosis was invalid for the date(s) of service reported.	**0296**	**DIAGNOSIS CODE NOT ON FILE**	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	**0919**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**	MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	**0920**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**	MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.
146 (06/18/07)	Diagnosis was invalid for the date(s) of service reported.	**1801**	**CLAIM CHECK: CLM DIAG INVALID BASED ON ICD-9 EXPIRATION DT**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	**1802**	**CLAIM CHECK: CLM DIAGNOSIS INVALID ICD-10**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	**1843**	**CLAIM CHECK: INVALID DIAGNOSIS CODE**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	**1847**	**CLAIM CHECK: INVALID DIAGNOSIS CODE**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	**1879**	**CLAIM CHECK: DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DT**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	**1880**	**CLAIM CHECK: DIAGNOSIS INVALID ICD-10**	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
147 (10/16/03)	Provider contracted/negotiated rate expired or not on file.	**0619**	**VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	**0540**	**COMPOUND DRUG FOR GSHP BENEFICIARY**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	**0544**	**DRUG NOT PAYABLE FEDERAL DESI**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	**0555**	**PAAD RECIP INELIGIBLE FOR MEDICAID SERVICES**	N30 (10/16/03)	Patient ineligible for this service.
150 (01/01/16)	Payer deems the information submitted does not support this level of service.	**0792**	**ADJUSTMENT TO CONVERTED CLAIM**	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
150 (11/01/15)	Payer deems the information submitted does not support this level of service.	**1279**	**CALCULATED PAYMENT AMOUNT ZERO**	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
150 (01/01/15)	Payer deems the information submitted does not support this level of service.	**1341**	**INVALID REVENUE CODE FOR OUTPATIENT OBSERVATION SERVICES**	M50 (01/01/15)	Missing/incomplete/invalid revenue code(s).
150 (01/29/16)	Payer deems the information submitted does not support this level of service.	**2073**	**REQUESTOR IS NOT AUTHORIZED TO VOID/ADJUST THIS CLAIM**		
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**0710**	**UNABLE TO DETERMINE LEAVE PERIOD-ADJUSTMENT MAY BE REQUIRED**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
151 (09/01/20)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**0791**	**ADJUSTMENT REQUIRES MANUAL UPDATE**	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**0793**	**ADJUSTMENT PENDED FOR ARCHIVE CYCLE**	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**0843**	**ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC**	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.
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**1013**	**OP XOVER PR RE-PRICING**	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.
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	**1611**	**PARTIAL PR-1 DEDUCTION APPLIED**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
153 (10/16/03)	Payer deems the information submitted does not support this dosage.	**0413**	**2 PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
153 (10/16/03)	Payer deems the information submitted does not support this dosage.	**0414**	**1 PRESCRIPTION REMAINS WITHOUT NEED FOR PRIOR AUTHORIZATION**	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
153 (04/01/18)	Payer deems the information submitted does not support this dosage.	**0415**	**NO PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**	N59 (04/01/18)	Alert: Please refer to your provider manual for additional program and provider information.
153 (01/03/16)	Payer deems the information submitted does not support this dosage.	**0463**	**UNIT RECAPTURE ADJUSTMENTS**		
153 (01/01/16)	Payer deems the information submitted does not support this dosage.	**2046**	**PRESCRIPTION NOT ALLOWED DUE TO CHANGE IN THERAPY**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
153 (01/29/16)	Payer deems the information submitted does not support this dosage.	**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**	**ANTIPSYCHTIC DRUG-OVERLAPPING USAGE OF 2+ DRUGS > 42 DAYS**		
154 (02/01/16)	Payer deems the information submitted does not support this day's supply.	**0395**	**INITIAL PRESCRIPTION LIMITED TO A 34 DAY SUPLY**		
154 (01/29/16)	Payer deems the information submitted does not support this day's supply.	**0396**	**REFILL RX LIMITED TO 34 DAYS / 100 UNITS**		
154 (01/01/14)	Payer deems the information submitted does not support this day's supply.	**0548**	**DAYS SUPPLY EXCEEDS PROGRAM MAX**	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.
163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.	**0196**	**TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER**	N3 (01/01/16)	Missing consent form.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0199**	**SUBMIT HARD COPY CLAIM AND MEDICARE EOB**	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0239**	**ALTERED DOCUMENTATION-ORIGINAL PRICE LIST/INVOICE NEEDED**	N445 (11/01/15)	Missing document for actual cost or paid amount.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0335**	**ABORTION CERTIFICATION FORM REQUIRED**	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.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0336**	**ABORTION REQUIRES REVIEW**	M60 (11/01/15)	Missing Certificate of Medical Necessity.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0337**	**STERILIZATION FORM REQUIRES REVIEW**	M60 (11/01/15)	Missing Certificate of Medical Necessity.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0341**	**INSUFFICIENT MEDICAL DOCUMENTATION FOR ABORTION**	M127 (11/01/15)	Missing patient medical record for this service.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0354**	**HYSTERECTOMY REQUIRES ATTACHMENT**	N398 (11/01/15)	Missing elective consent form.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0452**	**CERTIFICATION OF EMERGENCY FORM MISSING/INVALID**	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0453**	**PA/CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM**	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0471**	**FQHC ENCOUNTER WITH NO PD HCPCS ON HIST**	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.	**0842**	**ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED**	N706 (01/01/16)	Missing documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**0878**	**NO EMERGENCY CLAIM FOR ALIEN TRANSPORTATION CLAIM**	N391 (11/01/15)	Missing emergency department records.
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	**0980**	**EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM**	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**1610**	**NO MATCH FOUND IN HISTORY FOR HOSPITAL ADJUSTMENT**	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	**1628**	**REQUIRED DENTAL CLAIM NOT RECEIVED FOR SAME DOS**	N279 (11/01/15)	Missing/incomplete/invalid pay-to provider name.
163 (06/26/17)	Attachment/other documentation referenced on the claim was not received.	**1675**	**CCBHC ENCOUNTER WITH NO PD CCBHC ON HIST**	N214 (06/26/17)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (07/01/21)	Attachment/other documentation referenced on the claim was not received.	**1709**	**OORP WEEKLY SERVICE(X4) WITH NO PD INIT SVC (X3)**	N214 (07/01/21)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (01/01/22)	Attachment/other documentation referenced on the claim was not received.	**1710**	**INCK SCREENING & NO PAID ANNUAL OR E&M VISIT PAID**	N214 (01/01/22)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	**2096**	**PATIENT PAID AMOUNT UNKNOWN - 433-DX**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	**2110**	**PATIENT PAID AMOUNT UNKNOWN**		
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	**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.	**2210**	**NO SIGNATURE ON CLAIM LOG**		
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	**2212**	**INVOICE IS ILLEGIBLE**		
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**0026**	**CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING LIMITS**	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**0027**	**INPATIENT CLAIM W/O ATTACHMENT EXCEEDS TIMELY FILING LIMITS**	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**0029**	**MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT**	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**0076**	**CLAIM W/ATTACH EXCEEDS TIMELY FILING**	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**0077**	**I/P CLAIM EXCEEDS TIMELY FILING LIMIT**	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
166 (01/01/15)	These services were submitted after this payers responsibility for processing claims under this plan ended.	**1347**	**MLTSS WAIVER FFS CLAIM REPROCESS.**	N663 (01/01/15)	Adjusted based on an agreed amount.
166 (01/29/16)	These services were submitted after this payers responsibility for processing claims under this plan ended.	**2277**	**VOID RECEIVED AFTER HOURS-HELD UNTIL POS SYSTEM AVAILABLE**		
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.	**0332**	**STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21**	N30 (11/01/15)	Patient ineligible for this service.
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.	**0881**	**URO/DRG AUDIT ADJUST - REQUEST DENIED**	N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).
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.	**0924**	**DISCHARGE DATE AND READMIT DATE WITHIN SET TIME SPANS FOR NY**	N647 (01/01/14)	Adjusted based on diagnosis-related group (DRG).
169 (01/29/16)	Alternate benefit has been provided.	**2228**	**PAYER-PAT DATA FOR HEALTH PLAN FUNDED ASSISTANCE(129-UD) > 0**		
169 (01/29/16)	Alternate benefit has been provided.	**2276**	**BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED**		
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.	**0696**	**CLAIM DENIED PROVIDER NOT REENROLLED**	M143 (11/01/15)	The provider must update license information with the payer.
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.	**1326**	**INVALID PROVIDER TYPE FOR ATTENDING PROVIDER**	N95 (04/02/10)	This provider type/provider specialty may not bill this service.
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.	**1383**	**INVALID PROVIDER TYPE - OPERATING 1**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1384**	**INVALID PROVIDER TYPE - OPERATING 2 PHYSICIAN**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
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.	**1385**	**PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - SERVICING**	N95 (02/01/16)	This provider type/provider specialty may not bill this 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.	**1452**	**NON-MEDICAID PROVIDER NOT ELIGIBLE FOR SERVICE**	N95 (02/20/17)	This provider type/provider specialty may not bill this service.
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.	**1455**	**NOT A COVERED SERVICE UNDER NJ MEDICAID**	N95 (08/06/18)	This provider type/provider specialty may not bill this service.
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.	**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.	**2270**	**PROVIDER ONLY AUTHORIZED TO PRESCRIBE-NOT A BILLING PROV**		
173 (01/29/16)	Service/equipment was not prescribed by a physician.	**2176**	**INELIGIBLE PRESCRIBER BASED ON CMS LIST**		
173 (01/29/16)	Service/equipment was not prescribed by a physician.	**2190**	**RETURNED TO STOCK PRESCRIPTION**		
174 (01/29/16)	Service was not prescribed prior to delivery.	**2194**	**RX DISPENSED AFTER DATE OF DEATH**		
174 (01/29/16)	Service was not prescribed prior to delivery.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
175 (01/01/16)	Prescription is incomplete.	**0447**	**DAILY DOSE EXCEEDS REC.LIMITS FOR DRUG FOUND IN COMBO PROD.**		
175 (01/03/16)	Prescription is incomplete.	**0466**	**COMPOUND CLAIM WITH ONLY ONE INGREDIENT**		
175 (01/29/16)	Prescription is incomplete.	**0756**	**DRUG SUPPLIED EARLY - REVIEW REQUIRED**		
175 (01/29/16)	Prescription is incomplete.	**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.	**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 (03/01/21)	Prescription is incomplete.	**1707**	**COVID VACCINE ADMINISTRATION CONFLICT**	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.
175 (03/01/21)	Prescription is incomplete.	**1708**	**MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES**	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.
175 (01/01/16)	Prescription is incomplete.	**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.	**2003**	**COMPOUND DRUG-INCORRECT INGREDIENT QUANTITY/COST**		
175 (01/01/16)	Prescription is incomplete.	**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.	**2047**	**PA REQUIRED: DRUG / PRESCRIBER RESTRICTION**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
175 (12/13/22)	Prescription is incomplete.	**2138**	**ANONYMOUS NALOXONE BUDGET LIMIT EXCEEDED FOR THE FY**	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.
175 (01/29/16)	Prescription is incomplete.	**2143**	**MINIMUM 180 DAYS REQUIRED FOR VACCINATION CLAIM**		
175 (09/01/20)	Prescription is incomplete.	**2153**	**RX INCORRECTLY SUBMITTED AS A COMPOUND**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	**2154**	**INITIAL CONTROLLED DRUG FILLED > 30 DAYS PAST DATE WRITTEN**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	**2156**	**RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCRBR NPI**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	**2162**	**RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCR INFO**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	**2166**	**INCORRECT COMPOUND INGREDIENT NDC# SUBMITTED**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	**2175**	**NO NAME ON RX**	N668 (09/01/20)	Incomplete/invalid prescription.
175 (01/29/16)	Prescription is incomplete.	**2182**	**RX INCOMPLETE; MISSING DATE WRITTEN**		
175 (01/29/16)	Prescription is incomplete.	**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.	**2193**	**MISSING/INCOMPLETE SIGNATURE/DELIVERY LOG/CERTIF STATEMENT**		
175 (01/29/16)	Prescription is incomplete.	**2207**	**RX INCOMPLETE/MISSING/AMBIG/INCOMPLETE PRESCRIBER SIGNATURE**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2285**	**COMPOUND INGREDIENT DRUG COST IS NON-NUMERIC OR NEGATIVE**		
175 (04/01/17)	Prescription is incomplete.	**2296**	**CLAIM NOT ELIGIBLE FOR 340B PRICING**	M86 (04/01/17)	Service denied because payment already made for same/similar procedure within set time frame.
175 (01/29/16)	Prescription is incomplete.	**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.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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 (09/01/20)	Prescription is incomplete.	**2331**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II-V**	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.
175 (09/20/20)	Prescription is incomplete.	**2332**	**DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG**	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.
175 (09/20/20)	Prescription is incomplete.	**2333**	**460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED**	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.
175 (09/20/20)	Prescription is incomplete.	**2334**	**QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM**	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.
175 (09/20/20)	Prescription is incomplete.	**2335**	**QTY DISPENSED > QTY PRESCRIBED**	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.
175 (09/20/20)	Prescription is incomplete.	**2336**	**NUM OF REFILLS AUTH > O SCHED II**	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.
175 (09/20/20)	Prescription is incomplete.	**2337**	**403-3D FILL NUMBER M/I**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
175 (09/20/20)	Prescription is incomplete.	**2338**	**403-D3 NUMBER > O ON SCHED II**	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.
175 (09/20/20)	Prescription is incomplete.	**2340**	**343-HD DISPENSING STATUS INVALID**	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.
175 (09/20/20)	Prescription is incomplete.	**2342**	**ACCUM OF MED EXCEEDS 30 DAYS 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.
175 (09/20/20)	Prescription is incomplete.	**2350**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II - V**	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.
175 (02/28/22)	Prescription is incomplete.	**2351**	**OTC COVID TEST EXCEEDED- LIMIT 4 KITS PER MONTH**	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.
176 (01/29/16)	Prescription is not current.	**0416**	**PRESCRIPTION VOLUME EXCEEDS THRESHOLD - PA REQUIRED**		
177 (01/03/16)	Patient has not met the required eligibility requirements.	**0449**	**"INAPPROPRIATE NARCOTIC USE"**		
177 (01/01/16)	Patient has not met the required eligibility requirements.	**2004**	**CLAIM PENDING RE-ENROLLMENT**		
181 (11/01/15)	Procedure code was invalid on the date of service.	**0253**	**REVENUE/PROCEDURE NOT VALID ON DATE(S) OF SERVICE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
181 (01/01/16)	Procedure code was invalid on the date of service.	**0597**	**VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE**	N517 (01/01/16)	Resubmit a new claim with the requested information.
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.	**1325**	**INVALID PROVIDER TYPE FOR REFERRING PROVIDER**	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.
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.	**1336**	**INVALID REFERRING PROVIDER FOR PLACE OF SERVICE 2 OR 4**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1391**	**REFERRING PROVIDER INELIGIBLE ON DATES OF SERVICE**	N630 (11/01/15)	Referral not authorized by attending physician.
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.	**0546**	**PAAD/SR GOLD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER**	N950 (07/12/21)	
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.	**0885**	**NON PAR. PHARM PROV SERV W/PA 6/01/01 PAAD/ SENIOR GOLD**		
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.	**1382**	**INVALID PROVIDER TYPE - PRESCRIBING PHYSICIAN**	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.
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.	**1390**	**PRESCRIBING PROVIDER INELIGIBLE ON DATES OF SERVICE**	N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.
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.	**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.	**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.	**2266**	**INELIGIBLE PRESCRIBER, 15-DAY GRACE PERIOD BEGINS FOR RECIP**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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**		
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.	**0203**	**PROVIDER ON REVIEW - STATE PEND**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**0207**	**BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**0243**	**PROVIDER NOT AUTHORIZED-TARGETED CASE MANAGEMENT**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0281**	**POS VOID TRANSACTION FOR PROVIDER-ON-REVIEW**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**0282**	**POS PROVIDER ON REVIEW-NO Z NO OVERRIDE**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**0691**	**PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVIC**	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**0697**	**CLAIM PENDED PROVIDER RE-ENROLLMENT NOT COMPLETED**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
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.	**1424**	**NO ASSOCIATION FOUND FOR DDD-SP/CCW SVC LOCATION NPI**	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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.	**1429**	**DDD-SP/CCW SVC LOCATION NPI IS INELIGIBLE FOR DOS**	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.
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.	**1647**	**REVENUE CODE INVALID FOR LONG TERM PSYCH CLAIMS**	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).
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.	**2117**	**INCORRECT BILLING PROVIDER NUMBER FOR INSTITUTIONAL SERVICES**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**2248**	**FACILITY ID NOT ON FILE FOR ACTIVE LTC PROVIDER**		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	**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.	**0916**	**SEVERE DRUG/DRUG INTERACTION DUR**		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	**0917**	**MODERATE DRUG/DRUG INTERACTION DUR**	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.
194 (01/01/14)	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	**0758**	**SURGERY/ANESTHESIA CONFLICT - ANESTHESIA DENIED**	M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.
197 (01/29/16)	Precertification/authorization/notification/pre-treatment absent.	**2284**	**DRUG SUBJECT TO MEDICAL REVIEW**		
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	**0410**	**SERVICE NOT AUTHORIZED BY GSHP CASE MANAGER**	N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0772**	**PA/PROVIDER NOT AUTHORIZED**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0773**	**DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE(S)**	N531 (01/01/14)	Not qualified for recovery based on direct payment of premium.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0774**	**PRIOR AUTHORIZATION NOT ON FILE**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0775**	**PA RECORD ON FILE IS NOT ACTIVE**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.	**0776**	**PA DOLLARS/UNITS EXHAUSTED-CUTBACK**	N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	**0777**	**GSHP PA ALREADY PROCESSED**	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0779**	**MEDICAID PRIOR AUTHORIZATION NUMBER INVALID**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0780**	**GSHP PRIOR AUTHORIZATION NOT ON FILE**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0781**	**GSHP PRIOR AUTHORIZATION RECORD NOT ACTIVE**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0782**	**GSHP DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE**	N351 (01/01/14)	Service date outside of the approved treatment plan service dates.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0783**	**GSHP PROCEDURE NOT INCLUDED IN PRIOR AUTHORIZATION**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.	**0784**	**GSHP PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED**	N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0867**	**PCA SERVICES > 25 HRS. & VALID PA NUMBER NOT ON CLAIM.**	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	**0868**	**PCA UNITS OF SERVICE EXCEEDS WEEKLY ALLOWABLE ON THE PA.**	M62 (01/02/14)	Missing/incomplete/invalid treatment authorization code.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	**0926**	**AUTHORIZATION PERIOD FOR ORTHO SVCS EXCEEDED/ PA REQUIRED**	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	**1617**	**PA NUMBER CHANGED SYSTEMATICALLY**	N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.
199 (11/01/15)	Revenue code and Procedure code do not match.	**0058**	**INV/MISS PROCEDURE CODE/REVENUE CODE/CHARGE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
199 (11/01/15)	Revenue code and Procedure code do not match.	**0665**	**PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
199 (03/29/10)	Revenue code and Procedure code do not match.	**1328**	**BILL OUTPATIENT DRUG CLAIMS USING REVENUE CODES 631 THRU 637**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	**0303**	**RECIPIENT IS SERVICE OR PROVIDER RESTRICTED**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	**0310**	**GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0404**	**DURATION STANDARD EXCEEDED - POSSIBLE CUTBACK**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**0446**	**DRUG NOT COVERED BY CF PROGRAM**		
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0535**	**DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION PERIOD AUTHORIZED**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0536**	**DAILY QUANTITY POSSIBLY EXCEEDED**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0537**	**DAILY DRUG QUANTITY EXCEEDED; IMMEDIATE PA REQUIRED**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0538**	**DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**0615**	**DRG NOT EFFECTIVE ON CLAIM SERVICE DATE**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (10/01/19)	This service/equipment/drug is not covered under the patient's current benefit plan	**1011**	**NOT A FAMILY PLANNING SVC/NOT ATTESTED PLANNING SVC**	N30 (10/01/19)	Patient ineligible for this service.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	**1216**	**DRUG REBATE INDICATOR ZERO OR NO MCAID/GA REBATE AGREEMENT**	N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan	**1407**	**NOT A COVERED SERVICE UNDER MSP FOR SLMB OR QI**	N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan	**1467**	**NOT A COVERED SERVICE UNDER MSP FOR QMB**	N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**2032**	**DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**2033**	**PAAD/SG/ADDP CLAIMS ONLY - PAID CLAIMS FOR NON PART D DRUG**		
204 (02/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**2044**	**PART D-EMERGENCY SUPPLY MAY BE FILLED ONLY ONCE IN 90 DAYS**		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**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	**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	**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	**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	**2131**	**CMS UNMATCHED NDC ACCORDING TO FDB EDITORIAL (BLENDED) INFO**		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**2135**	**EDI AGREEMENT REQUIRED FOR NCPDP D.O CLAIM**	M44 (04/05/11)	Missing/incomplete/invalid condition code.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**2157**	**DOC HAS NO DIRECTIONS (SIG) FOR USE/EXCESSIVE QTY OF DAYS**	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**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	**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	**2237**	**OTHER PAYER-PATIENT RESP AMT COUNT NOT EQUAL # REPETITIONS**		
204 (11/20/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**2343**	**NDC PRICING EXCEEDS CLASS AVG; CHANGE NDC OR PA NEEDED**	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.
206 (11/01/15)	National Provider Identifier - missing.	**0949**	**CLAIM VOIDED - BILLING PROVIDER ERROR**	N253 (11/01/15)	Missing/incomplete/invalid attending provider primary identifier.
207 (11/01/15)	National Provider identifier - Invalid format	**0212**	**SERV PROV NOF/ LTC COTTAGE NUMBER INVALID**	N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.
208 (11/01/15)	National Provider Identifier - Not matched.	**0216**	**SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED**	N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.
208 (11/01/15)	National Provider Identifier - Not matched.	**0217**	**LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD:CUTBACK**	N77 (11/01/15)	Missing/incomplete/invalid designated provider number.
208 (08/16/10)	National Provider Identifier - Not matched.	**1329**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	N77 (08/16/10)	Missing/incomplete/invalid designated provider number.
208 (08/16/10)	National Provider Identifier - Not matched.	**1334**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	N77 (08/16/10)	Missing/incomplete/invalid designated provider number.
210 (01/01/14)	Payment adjusted because pre-certification/authorization not received in a timely fashion	**0409**	**PROSTHETIC AND/OR ORTHOTIC CHARGES REQUIRES PA**	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
212 (01/01/16)	Administrative surcharges are not covered	**2137**	**PART D COPAY NOT COVERED AS OF FY2012**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0407**	**THERAPEUTIC DUPE; CLAIM THRESHOLD EXCEEDED**		
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.	**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 (01/01/14)	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.	**0768**	**EXCESSIVE PRIVATE DUTY NURSING HOURS-PA REQUIRED**	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
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.	**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.	**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**		

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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 (01/01/15)	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.	**1651**	**MAX UNITS REACHED FOR 2 CONSECUTIVE DAY OCCURRENCE**	N362 (01/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	**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**		
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.)	**0417**	**GENERIC SUBSTITUTION REQUIRED OR INAPPROPRIATE DAW**	M44 (10/16/03)	Missing/incomplete/invalid condition code.
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.)	**0530**	**LTC OVERLAPPING LEAVE PERIODS**	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.)	**1349**	**VERIFY METRIC QUANTITY REPORTED**	N378 (05/02/11)	Missing/incomplete/invalid prescription quantity.
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.)	**1459**	**PRA INVALID- NO RECIPIENT FOUND FOR PRENATAL SERVICE**	N705 (12/07/20)	Incomplete/invalid documentation.
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.)	**1464**	**PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE**	N705 (08/17/21)	Incomplete/invalid documentation.
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.)	**1465**	**PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS**	N705 (08/17/21)	Incomplete/invalid documentation.
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.	**0722**	**SERVICE/VISIT CONFLICT**	N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
233 (01/01/14)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	**1340**	**PROVIDER PREVENTABLE CONDITION - NOT COVERED**	N567 (05/01/16)	Not covered when considered preventative.
233 (12/09/13)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	**1401**	**PAYMENT ADJUSTED FOR HOSPITAL ACQUIRED CONDITION**	N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).
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.)	**0486**	**PHARMACY {DRUGS} INCLUDED IN ESRD COMPOSITE RATE**	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.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.)	**0487**	**MEDICAL SUPPLIES INCLUDED IN THE ESRD COMPOSITE RATE**	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.
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.)	**0746**	**MASS ADJ: BILLED CHARGES MODIFIED TO PERMIT ADJ-SEE REC-569**	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.
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.)	**1322**	**SERVICE/PROCEDURE INCLUDED IN COMPOSITE RATE**	N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
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.)	**1605**	**FQHC PAID HIGHEST DELIVERY, OB/GYN OR ENCOUNTER CLAIM**	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.
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.)	**1655**	**SERVICE/VISIT CONFLICT**	N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
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.)	**2195**	**QUANTITY BILLED IS GREATER THAN THE QUANTITY DELIVERED**		
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.	**0725**	**BIOPSY D&C CONFLICT**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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)	**1408**	**HOSPICE CUTBACK DAY OF REVOCATION**	MA31 (09/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.
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)	**1409**	**HOSPICE DATE OF DEATH PAYMENT CUTBACK**	MA31 (06/29/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0043**	**INV/MISS BIRTH WEIGHT**	N207 (11/01/15)	Missing/incomplete/invalid weight.
242 (01/01/14)	Services not provided by network/primary care providers.	**0219**	**PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION**	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
242 (01/01/14)	Services not provided by network/primary care providers.	**0221**	**PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE**	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
242 (01/01/14)	Services not provided by network/primary care providers.	**0690**	**PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM.**	N95 (01/28/05)	This provider type/provider specialty may not bill this service.
243 (11/01/15)	Services not authorized by network/primary care providers.	**0226**	**BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
243 (11/01/15)	Services not authorized by network/primary care providers.	**0229**	**SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO.OR MORE**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
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).	**0191**	**REVIEW RA MESSAGE PAGE FOR EXPLANATION**	N206 (11/01/15)	The supporting documentation does not match the information sent on the 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).	**0338**	**HYSTERECTOMY PROC REQ REVIEW OF HYST RECEIPT OF INFO FORM**	N175 (11/01/15)	Missing review organization approval.
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).	**0366**	**MISSING/INVALID STERILIZATION TIME REASON**	N463 (11/01/15)	Missing support data for claim.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0505**	**LTC CENSUS DATA MISSING FOR SERVICE MONTH AND YEAR**	M127 (11/01/15)	Missing patient medical record for this service.
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).	**0641**	**RX FROM PHYSICIAN REQUIRED**	N667 (11/01/15)	Missing prescription.
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).	**0874**	**ADJ/VOID AND MATCHING HISTORY CLAIM MUST BOTH BE MEDIA 7**	N221 (11/01/15)	Missing Admitting History and Physical report.
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).	**0889**	**GA MATCHING HISTORY NOT FOUND**	N221 (11/01/15)	Missing Admitting History and Physical report.
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).	**0909**	**REQUIRES MATCHING EPSDT CLAIM FOR PAYMENT**	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0940**	**CLAIM REQUIRES REVIEW - MEDICARE PART A ATTACHMENT**	M124 (11/01/15)	Missing indication of whether the patient owns the equipment that requires the part or supply.
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).	**0957**	**CLAIM CORRECTED OR REPROCESSED BY REQUEST**	N26 (01/29/16)	Missing itemized bill/statement.
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).	**1604**	**NO FQHC DELIVERY, OB/GYN OR ENCOUNTER MATCHING CLAIM**	N206 (11/01/15)	The supporting documentation does not match the information sent on the 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).	**1685**	**NO FQHC GROUP COUNSELING MATCHING CLAIM**	N206 (11/01/19)	The supporting documentation does not match the information sent on the claim.
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).	**0092**	**INV/MISS EPSDT IMMUNIZATION STATUS CODE(S)**	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.

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

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0099**	**EPSDT WIC INDICATOR INVALID OR MISSING**	N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.
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).	**0105**	**FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15**	N446 (11/01/15)	Incomplete/invalid document for actual cost or paid amount.
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).	**0251**	**PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
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).	**0318**	**MED NEEDY SPENDDOWN RECIP- ATTACHMENT REVIEW**	N225 (01/01/16)	Incomplete/invalid documentation/orders/notes/summary/report/chart.
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).	**0460**	**INSURANCE ATTACHMENT INVALID/MISSING**	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
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).	**0598**	**INVALID LEVEL-OF-CARE CODE**	M135 (11/01/15)	Missing/incomplete/invalid plan of treatment.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0640**	**INVOICE/PRICE LIST ATTACHED IS INVALID/INSUFFICIENT**	N354 (11/01/15)	Incomplete/invalid invoice.
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).	**0650**	**MISSING PENNSYLVANNIA HOSPITAL FISCAL YEAR DATA**	N570 (11/01/15)	Missing/incomplete/invalid credentialing data.
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).	**0838**	**PROVIDER-PRODUCED EOB INCOMPLETE**	N705 (05/01/16)	Incomplete/invalid documentation.
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).	**0839**	**ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS**	N255 (01/01/14)	Missing/incomplete/invalid billing provider taxonomy.
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).	**0848**	**ADJUST CLM MISSING PAYER/CARRIER CODE AND/OR TPL PAYMENT**	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
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).	**0948**	**EOB MISSING FOR CARRIER/PAYOR REPORTED ON CLAIM**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0971**	**MISSING CARRIER CODE/PAYOR ID**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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).	**0974**	**TPL PAYMENT AMOUNT FROM EOB MISSING ON CLAIM**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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).	**0019**	**INVALID INTERNAL CONTROL NUMBER (ICN)**	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).
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).	**0245**	**ATTACHMENT REQUIRED OR INCORRECT ATTACHMENT FOR PROCEDURES**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
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).	**0261**	**OPERATIVE/ANES. , HISTORY AND/OR PATH REPORT REQUESTED.**	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
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).	**0264**	**SPECIAL PROGRAM CODE - REVIEW ATTACHMENT**	N175 (11/01/15)	Missing review organization approval.
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).	**0320**	**MED NEEDY SPENDDOWN - INVALID/MISSING ATTACHMENT**	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0349**	**SEC OPINION FORM INCOMPLETE,MISSING DATA OR IS OUT OF DATE**	N706 (11/01/15)	Missing documentation.
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).	**0352**	**INSUFFICIENT MEDICAL DOCUMENTATION FOR STERILIZATION**	N706 (11/01/15)	Missing documentation.
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).	**0353**	**ATTACHED FORM DATA INCORRECT/MISSING/ILLEGIBLE**	N28 (11/01/15)	Consent form requirements not fulfilled.
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).	**0355**	**STERILIZATION FORM REQUIRED**	N706 (11/01/15)	Missing documentation.
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).	**0386**	**KID-CARE UNABLE TO DETERMINE COVERAGE**	N375 (11/01/15)	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
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).	**0464**	**HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED**	N706 (11/01/15)	Missing documentation.
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).	**0669**	**DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED**	N350 (11/01/15)	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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).	**0847**	**INCORRECT ICN ON FD-999**	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).
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).	**0965**	**MEDICARE INPATIENT PART A EOB MISSING**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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).	**0966**	**MEDICARE INPATIENT PART B EOB MISSING**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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).	**0967**	**MEDICARE PHYSICIAN PART B EOB MISSING**	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
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).	**0995**	**NO MATCHING HISTORY CLAIM FOR CREDIT RECORD**	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).
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).	**0997**	**IMAGINERY CLAIM - REVIEW REQUIRED**	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).
256 (11/01/15)	Service not payable per managed care contract.	**1327**	**HMO RESPONSIBLE FOR NON-ABP FACILITY COSTS**	N95 (07/01/09)	This provider type/provider specialty may not bill this service.
256 (11/01/15)	Service not payable per managed care contract.	**1338**	**ESRD BILLABLE SERVICE**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
256 (11/01/15)	Service not payable per managed care contract.	**1381**	**ACTIVE MANAGED CARE FOUND W/O ACTIVE ELIGIBILITY**	N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0506**	**RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES**	N30 (01/01/14)	Patient ineligible for this 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.	**1313**	**INVALID CLAIM TYPE FOR DEPT OF CORRECTIONS**	N193 (11/01/15)	Alert: Specific federal/state/local program may cover this service through another payer.
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.	**1316**	**CLAIMS FOR DEPARTMENT CORRECTIONS INMATE**	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.
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.	**1318**	**DOC RECIPIENT INELIG ON DATE OF SERVICE**	N30 (10/01/08)	Patient ineligible for this 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.	**1319**	**DOC RECIPIENT NOT ON FILE**	N30 (10/01/08)	Patient ineligible for this service.
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.	**2290**	**PHARMACY CLAIM NOT PAYABLE FOR SPC 98 OR 99**	N30 (11/10/14)	Patient ineligible for this service.
261 (01/29/16)	The procedure or service is inconsistent with the patient's history.	**0887**	**POS/MATCHING HISTORY NOT FOUND**		
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.)	**0908**	**UNABLE TO PRICE MULTIPLE SURGERY CLAIM**	N61 (11/01/15)	Rebill services on separate 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.	**0268**	**ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE**	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this 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.	**1629**	**DENTAL ANESTHESIA CLAIM CUTBACK BY BEHAVIOR MANAGEMNT CLAIMS**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
272 (01/01/21)	Coverage/program guidelines were not met.	**1703**	**POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D**	N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
275 (06/13/13)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	**0960**	**CLAIM UPDATED WITH PATIENT PAYMENT**		
275 (06/13/16)	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**		
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.	**0539**	**THIS LIVERY SVC IS ONLY VALID IN COUNTIES 07, 09 AND 90**	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
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.	**0942**	**CLAIM VOIDED DUE TO POST-PAYMENT REVIEW BY MUNICIPALITY.**	N35 (10/16/03)	Program integrity/utilization review decision.
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.	**1363**	**CANNOT CHANGE A DOCUMENT LEVEL SURGERY**	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**1364**	**CANNOT ADJUST A LINE LEVEL SURGERY**	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
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.	**1860**	**CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE**	N569 (12/01/22)	Not covered when performed for the reported diagnosis.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
A8 (11/01/15)	Ungroupable DRG.	**0480**	**GROUPER ASSIGNED A NEW DRG CODE**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	**0242**	**SPECIAL PROGRAM/PROGRAM STATUS CODE-PROCEDURE RESTRICTION**	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.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	**0244**	**INVALID PROGRAM STATUS FOR SEMI PROCDURES**	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.
B5 (01/01/14)	Coverage/program guidelines were not met or were exceeded.	**0626**	**PAYMENT REDUCED TO MAC MAXIMUM**	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	**0732**	**ADJUSTMENT TO DENTURES WITHIN 6 MONTHS OF DELIVERY**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	**1008**	**CARRIER AMOUNT EXCEEDS MAXIMUM VALUE ALLOWED**	N640 (11/01/15)	Exceeds number/frequency approved/allowed within time period.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	**1202**	**PREMIUM SUPPORT PROGRAM - STATE REVIEW REQUIRED.**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
B5 (01/27/21)	Coverage/program guidelines were not met or were exceeded.	**1468**	**PROC CODE RESTRICT FOR NON-ADDP RECIEP(PSC NOT EQUAL TO 780)**	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.
B5 (07/01/23)	Coverage/program guidelines were not met or were exceeded.	**1472**	**SPECIAL PROGRAM CODE RESTRICTION FOR SERVICE DATE(S)**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0201**	**SERVICING PROVIDER NOT ELIGIBLE ON DATE(S) OF SERVICE**	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
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.	**0210**	**PROVIDER NOT CERTIFIED FOR THIS PROCEDURE**	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
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.	**0299**	**SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**	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.
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.	**0387**	**BILLING PROVIDER NOT ENROLLED IN CLIA**	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
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.	**0388**	**BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
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.	**0389**	**BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**	N570 (11/01/15)	Missing/incomplete/invalid credentialing data.
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.	**0436**	**SUBMITTER NOT ELIGIBLE FOR CLAIM TYPE ON ACTIVITY DATE**	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.
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.	**0440**	**LTC PHARMACY INELIGIBLE FOR UD RECYCLING.**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0593**	**CAPITATION CATEGORY RATE NOT IN EFFECT FOR DATE OF SERVICE**	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
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.	**2295**	**FACILITY PROVIDER IS NOT ACTIVE ON THE DATE OF SERVICE**		
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.	**0751**	**PAYMENT REDUCED - SURGERY/VISIT LIMITATION**	M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/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.	**0905**	**MULTIPLE SURGERY-REDUCED BY INCIDENTAL PROCEDURE**	M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
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.	**0976**	**MEDICAID PAYMENT REDUCED BY OTHER INSURANCE**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**0987**	**DEDUCT AMT INCLUDES MEDICARE OR PRIVATE INS REFUND TO STATE**	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.
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.	**1612**	**PARTIAL PATIENT PAYMENT AMOUNT APPLIED**	M144 (11/01/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
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.	**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.	**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**		

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**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**		
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.	**0894**	**OVERRIDE FOR EDIT 893**		
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.	**2039**	**EXEMPT LTC RECIPIENTS FROM MEDICARE PART CO-PAYMENT**		
B12 (11/01/15)	Services not documented in patient's medical records.	**0991**	**STATE APPROVED PAYMENT**	N199 (11/01/15)	Additional payment/recoupment approved based on payer-initiated review/audit.
B12 (01/29/16)	Services not documented in patient's medical records.	**2189**	**HMS-INITIATED FAIR HEARING OVERRIDE**		
B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0324**	**HMO COVERED SERVICE - PAYMENT NOT JUSTIFIED BY ATTACHMENT**	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.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0475**	**HISTORY RECORD ALREADY ADJUSTED OR VOIDED**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0742**	**PREVIOUS EXTRACTED TOOTH**	M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0749**	**ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0826**	**DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0876**	**CO-PAY FOR SERVICE DATE PAID - SEE CONFLICTING ICN ON RA**	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.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0888**	**CLAIM VOIDED DUE TO STATE AUDIT - SEE REMITTANCE MESSAGE 624**	N35 (10/16/03)	Program integrity/utilization review decision.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0914**	**ROUTINE PROCE CARRIED OUT IN NICU ARE INCL IN GLOBAL FEE**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0915**	**MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR**	M86 (11/01/15)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0921**	**SEVERE DRUG/DRUG INTERACTION - NO PA OVERRIDE CAPABILITY**	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.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0922**	**DRUG INDICATES PREGNANCY PRECAUTION WARNING**	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.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0931**	**OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**0935**	**GENERAL INPATIENT CARE & INPATIENT CLAIM BILLED SAME DAY**	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**1656**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**1657**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**1658**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NY**	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
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.	**0547**	**UNIT DOSE PAYABLE FOR NURSING HOME RECIPIENT ONLY**	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.

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**0723**	**LAB PANEL PROCEDURE CODE NOT ON FILE**	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).
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.	**1463**	**PENDING DOULA INCENTIVE PAYMENT FOR REPROCESS**	N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.
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.	**1682**	**TELEDENTISTRY CODE REQUIRES RELATED SERVICE CODE**	N357 (03/01/20)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
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.	**1686**	**SUD MGMT CLAIM WITH NO MATCHING E&M CLAIM**	N357 (01/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
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.	**1687**	**GROUP CLINICAL VISIT CLAIM WITH NO MATCHING E&M CLAIM**	N357 (12/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
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.	**1704**	**DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS**	N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 4/20/2025

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**1855**	**CLAIMSXTEN ADD ON EDIT**	N122 (12/01/22)	Add-on code cannot be billed by itself.
B18 (01/01/14)	This procedure code and modifier were invalid on the date of service.	**0545**	**NDC NOT ON DRUG FILE**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
B20 (11/01/15)	Procedure/service was partially or fully furnished by another provider.	**0788**	**ADJUSTMENT DENIED/ORIG PAID CORRECTLY**	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
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.	**2074**	**CLAIM HAS BEEN PREVIOUSLY VOIDED BY STATE - CANNOT RESUBMIT**		
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.	**0845**	**ADJUSTMENT DENIED/ EOMB REQUIRED**	N479 (01/01/16)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).

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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.	**0893**	**INSURANCE COVERAGE KNOWN, BILL TPL**		
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.	**0993**	**CLAIM DENIED AT PROVIDER REQUEST**	N55 (09/10/13)	Procedures for billing with group/referring/performing providers were not followed.
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.	**1621**	**DENY REASON CODE OR DENY EXPLANATION MISSING ON EOB**	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).