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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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

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

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

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

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		0893	**INSURANCE COVERAGE KNOWN, BILL TPL**	P21 (01/29/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
		0894	**OVERRIDE FOR EDIT 893**	B11 (01/29/16)	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
		0897	**EARLY REFILL-DIFFERENT PROVIDER-DENIED AFTER REVIEW**	175 (01/29/16)	Prescription is incomplete.
		0898	**EARLY REFILL-DIFFERENT PROVIDER WITH NO ATTACHMENT 08**	175 (01/29/16)	Prescription is incomplete.
		0916	**SEVERE DRUG/DRUG INTERACTION DUR**	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.
		0960	**CLAIM UPDATED WITH PATIENT PAYMENT**	275 (06/13/13)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
		0961	**SYSTEM UPDATE TO PATIENT INCOME**	275 (06/13/16)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
		1239	**MOTHER OF NEWBORN HAS SERVICE IN-PLAN**	128 (01/01/16)	Newborn's services are covered in the mother's Allowance.
		2000	**SERVICE ADMINISTRATIVELY DENIED**	39 (01/01/16)	Services denied at the time authorization/pre-certification was requested.
		2001	**COMPOUND CONTAINS DUPLICATE INGREDIENTS**	175 (01/01/16)	Prescription is incomplete.
		2002	**LTC COMPOUND MUST CONTAIN ACTUAL NDC**	175 (01/01/16)	Prescription is incomplete.

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

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

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

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		2053	**PART D REJECT CODE CONFLICTS WITH PDP PAYMENT AMOUNT**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2054	**CLAIM IS INCORRECTLY BILLED - NO MEDICARE ON FILE.**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2056	**THE LENGTH OF THE SERVICE/BILLING NPI IS INVALID**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2057	**SERVICE/BILLING PROVIDER NPI FAIL CHECK DIGIT 201-B1**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2058	**SERVICING/BILLING PROVIDER NPI IS REQUIRED OF 05/23/08**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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		2059	**THE FIRST DIGIT OF THE SERVICING/BILLING NPI IS INVALID**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2060	**THE MEDICAID ID IS NOT FOUND FOR SERVICING/BILLING NPI**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2061	**FOUND MULTIPLE MEDICAID IDS FOR THE SERVICING/BILLING NPI**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2062	**THE LENGTH OF THE PRESCRIBER NPI IS INVALID - 411-DB**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2063	**CHECK DIGIT VALIDATION FAIL FOR THE PRESCRIBER NPI**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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		2064	**PRESCRIBER NPI IS REQUIRED AS OF 05/23/08**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2065	**THE FIRST DIGIT OF PRESCRIBER NPI IS INVALID**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2069	**METRIC QUANTITY MUST REFLECT WHOLE PACKAGE**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2070	**EXCEEDS MAXIMUM METRIC QUANTITY FOR PACKAGE SIZE/ FULL PKGS**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2071	**PAAD RECIPIENTW/ MEDICAID ELIGIBILITY**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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

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

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

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

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

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

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		2238	**OTHER PAYER-PATIENT RESP AMT DOES NOT HAVE A CORRESP QUAL**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
		2239	**BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS.**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2240	**OTHER PAYER ID FIELD MISSING OR INVALID**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2241	**INVALID BENEFIT STAGE AMOUNT, NO PARTD PAYER SUBMITTED**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
		2242	**BENEFIT STAGE 50, NOT PART D-PART B DRUG PAID UNDER PART C**	B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
		2243	**BENEFIT STAGE 60 - NOT PART D - SUPPLEMENTAL BENEFIT**	B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
		2244	**BNFT STG 70-NOT PARTD CLM-PD BY NEGOTIATED PRICE-PARTD DRUG**	B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
		2245	**BNFT STG 80-NOT PARTD CLM-PD BY NGTIATED PRC-NOT PARTD DRUG**	B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
		2246	**BNFT STG 60/62/80/90 NOT ON FORMULARY EXCEPTION**	B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
		2247	**FACILITY ID IS MISSING OR INVALID**	58 (01/29/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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

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

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

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

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M25 (02/01/16)	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	**0843**	**ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC**	151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
M25 (11/01/15)	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	**1013**	**OP XOVER PR RE-PRICING**	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
M28 (10/16/03)	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	**0939**	**RECIPIENT IS MEDICARE PART A ELIGIBLE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M45 (10/16/03)	Missing/incomplete/invalid occurrence code(s).	**0461**	**ESRD CLAIM-OCCURRENCE CODE 35 REQUIRED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (01/01/14)	Missing/incomplete/invalid occurrence span code(s).	**1200**	**OCC SPAN DAY DOES NOT MATCH THE NUMBER OF REVENUE UNITS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (11/01/15)	Missing/incomplete/invalid occurrence span code(s).	**1284**	**INVALID/MISSING UB04 OCCURRENCE SPAN CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (12/09/13)	Missing/incomplete/invalid occurrence span code(s).	**1400**	**NO OCCURRENCE SPAN CODE 74 OR 77**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	**0019**	**INVALID INTERNAL CONTROL NUMBER (ICN)**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	**0036**	**INVALID ACUTE DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	**0037**	**INVALID SNF DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	**0038**	**INVALID ICF DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	**0039**	**INVALID RESIDENTIAL DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	**0046**	**TOTAL DAYS NOT EQUAL TO DATES OF SERVICE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**1353**	**DME AUDIT - INCORRECT RECIP IDENT - CALL (800) 310-0865**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**1354**	**DME AUDIT - NO PROOF OF PURCHADE - CALL (800) 310-0865**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**1355**	**DME AUDIT - NO PROOF OF DELIVERY - CALL (800) 310-0865**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**1356**	**DME AUDIT - NO PRESCRIBER ORDER - CALL (800) 310-0865**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**1357**	**DME AUDIT - DIFFERENT PROC/PRODUCT - CALL (800) 310-0865**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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M79 (11/01/15)	Missing/incomplete/invalid charge.	**0151**	**INV/MISS CLAIM LINE CHARGE(S)**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	**0175**	**BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (02/01/16)	Missing/incomplete/invalid charge.	**0607**	**LOW VARIANCE ERROR**	16 (02/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	**0646**	**MISSING NEW YORK REGIONAL BAD DEBT MULTIPLIER**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M79 (11/01/15)	Missing/incomplete/invalid charge.	**1010**	**INVALID LTC PATIENT/OTHER PAYMENT AMOUNT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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

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M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0749**	**ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE**	B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.	**0755**	**EARLY REFILL**	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0826**	**DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0914**	**ROUTINE PROCE CARRIED OUT IN NICU ARE INCL IN GLOBAL FEE**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (11/01/15)	Service denied because payment already made for same/similar procedure within set time frame.	**0915**	**MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0931**	**OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0935**	**GENERAL INPATIENT CARE & INPATIENT CLAIM BILLED SAME DAY**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.	**0976**	**MEDICAID PAYMENT REDUCED BY OTHER INSURANCE**	B10 (10/16/03)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	**1614**	**OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	**1630**	**MCARE LTC CLAIM WITH OVERLAPPING DOS**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	**1656**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**	B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.	**1657**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**	B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.

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

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M97 (10/16/03)	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	**0664**	**ITEM BILLED IS INCLUDED IN ADMINSTRATION/SUPPLY KIT**	97 (10/16/03)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M104 (02/01/16)	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.	**1899**	**CLAIM CHECK: BYPASS CLAIM CHECK**	109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0127**	**NDC CODE MISSING OR INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (01/01/14)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0252**	**PROC/REVENUE CODE/NDC/DIAG REQUIRES REVIEW**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0540**	**COMPOUND DRUG FOR GSHP BENEFICIARY**	150 (10/16/03)	Payer deems the information submitted does not support this level of service.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0542**	**NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0544**	**DRUG NOT PAYABLE FEDERAL DESI**	150 (10/16/03)	Payer deems the information submitted does not support this level of service.

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M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0545**	**NDC NOT ON DRUG FILE**	B18 (01/01/14)	This procedure code and modifier were invalid on the date of service.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0551**	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0553**	**COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**0559**	**COMPOUND DRUG-NDC CODE MISSING OR INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (06/04/07)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**1214**	**INVALID NDC OR NDC NOT ON FILE**	16 (06/04/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (09/01/20)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**2329**	**OPIOID NOT FOUND ON RGCNSTR0 TABLE**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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M124 (11/01/15)	Missing indication of whether the patient owns the equipment that requires the part or supply.	**0940**	**CLAIM REQUIRES REVIEW - MEDICARE PART A ATTACHMENT**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
M126 (01/01/14)	Missing/incomplete/invalid individual lab codes included in the test.	**0091**	**INV/MISS EPSDT LABORATORY INDICATOR**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M127 (11/01/15)	Missing patient medical record for this service.	**0341**	**INSUFFICIENT MEDICAL DOCUMENTATION FOR ABORTION**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
M127 (11/01/15)	Missing patient medical record for this service.	**0505**	**LTC CENSUS DATA MISSING FOR SERVICE MONTH AND YEAR**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.	**0322**	**HMO COVERED SERVICE -REVIEW REQUIRED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M129 (10/01/20)	Missing/incomplete/invalid indicator of x-ray availability for review.	**1365**	**HMS PERMEDION NJUR**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.	**1375**	**HMS CREDIT BALANCE RECOVERY - ON-SITE FINANCIAL REVIEW**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M135 (11/01/15)	Missing/incomplete/invalid plan of treatment.	**0598**	**INVALID LEVEL-OF-CARE CODE**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
M139 (01/01/16)	Denied services exceed the coverage limit for the demonstration.	**0610**	**MANUAL PRICING EXCEEDS BILLED CHARGES**	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
M139 (01/01/14)	Denied services exceed the coverage limit for the demonstration.	**1632**	**PROVIDER ADULT MDC UNIT EXCEEDS 200 UNIT PER DAY**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M143 (11/01/15)	The provider must update license information with the payer.	**0696**	**CLAIM DENIED PROVIDER NOT REENROLLED**	170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**0751**	**PAYMENT REDUCED - SURGERY/VISIT LIMITATION**	B10 (01/01/14)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**0905**	**MULTIPLE SURGERY-REDUCED BY INCIDENTAL PROCEDURE**	B10 (01/01/14)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
M144 (11/01/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**1612**	**PARTIAL PATIENT PAYMENT AMOUNT APPLIED**	B10 (11/01/15)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

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M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**1890**	**CLAIM CHECK: POST OPERATIVE PROCEDURE CODE**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**1891**	**CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA04 (11/01/15)	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**0192**	**MEDICAID NOT PRIMARY PAYOR SINCE TPL AMOUNT > ZERO**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	**0541**	**COMPOUND DRUG MANUAL REVIEW REQUIRED**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	**0563**	**NO BASE DISPENSING FEE ON FILE FOR CLAIM SERVICE DATE**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	**0564**	**NO VOLUME DISCOUNT ON FILE FOR CLAIM SERVICE DATE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	**0634**	**DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG PAYMENT DATE**	26 (10/16/03)	Expenses incurred prior to coverage.
MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.	**0992**	**SET LOCATION TO STATE REVIEW**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA07 (11/08/10)	Alert: The claim information has also been forwarded to Medicaid for review.	**1333**	**PLEASE CONTACT THE MANAGE CARE OFFICE AT 1-800-701-0710**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA100 (11/01/15)	Missing/incomplete/invalid date of current illness or symptoms.	**0343**	**INVALID/MISS STERILIZATION CONSENT DATE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (08/31/04)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	**0140**	**LABORATORY INDICATOR MUST BE Y OR N**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	**0260**	**DIAGNOSTIC REPORT (XRAYS,LAB,ETC.) REQUESTED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	**0726**	**INDIVID LAB TESTS EXCEEDS PANEL ALLOWANCE -REDUCED PAYMENT.**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.	**0298**	**SERVICE PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0125**	**THIS PROVIDER INVALID WITH MODIFIER UE OR U6 OR WI OR WR**	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0129**	**INVALID ATTACHMENT CODE GREATER THAN 17**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0168**	**MISSING MANDATORY PROCEDURE CODE MODIFIER**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0169**	**INVALID MODIFIER FOR PROC CODE,CLM TYPE OR SERVICE DATE**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0232**	**'YD' OR 'UD' MODIFIER NOT ALLOWED**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (04/01/18)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0335**	**ABORTION CERTIFICATION FORM REQUIRED**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0368**	**NOT LOCK IN PHARMACY/EMERGENCY SUPPLY DISPENSED**	31 (11/01/15)	Patient cannot be identified as our insured.
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0390**	**INVALID: REF PROV/ RCP CNTY/REF PROV TYP/PLC OF SVC FOR PROC**	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0394**	**MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD/SR GOLD PAYMENT**	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0476**	**NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0488**	**DRG INTERIM BILL APPROVAL REQUIRED**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0516**	**EPSDT FFS INCENTIVE PAYMENT ERROR**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0517**	**PASARR RECORD MISSING**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0518**	**INVALID PASARR DATA**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0548**	**DAYS SUPPLY EXCEEDS PROGRAM MAX**	154 (01/01/14)	Payer deems the information submitted does not support this day's supply.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0589**	**MODIFIER NOT ALLOWED**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0594**	**CLAIM NOT ELIGIBLE FOR ADD-ON DATE OF SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0603**	**PROVIDER NOT ON DRG RATE FILE**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0604**	**INVALID PRICING ACTION CODE**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0613**	**DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE**	26 (01/01/14)	Expenses incurred prior to coverage.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0624**	**NO VALID PRICE FOR DATE OF SERVICE ON USUAL & CUSTOMARY FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/16)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0794**	**FINANCIAL CORRECTION REQUIRED**	129 (01/01/16)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0869**	**POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT**	129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**0952**	**CLAIM VOIDED - RECIPIENT ID ERROR**	31 (10/16/03)	Patient cannot be identified as our insured.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1022**	**CAPITATION PAYMENT REDUCED BY MAX PATIENT PAYMENT LIABILITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1025**	**CAP PAYMENT PART REDUCED BY MAX PATIENT LIABILITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1249**	**MISSING PRIMARY PAYER IDENTIFICATION**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1250**	**MISSING SECONDARY PAYER IDENTIFICATION**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1251**	**MISSING TERTIARY PAYER IDENTIFICATION**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1253**	**SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1254**	**INVALID PRIMARY BENEFITS EXHAUST DATE**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1342**	**TENT PAY PRICE USING PHY FEE INCREASE-AFFORDABLE CARE ACT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1366**	**HMS RECOVERY - PATIENT DECEASED ON DOS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1429**	**DDD-SP/CCW SVC LOCATION NPI IS INELIGIBLE FOR DOS**	185 (11/07/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1430**	**OUTPATIENT TRANSPORTATION SERVICE HAS NO RATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1431**	**OUTPATIENT SERVICE NOT PAYABLE TRANS/PERS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1442**	**CLAIMS REPROCESS FOR DSNP MEMBERS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1451**	**UNKNOWN FIELD POPULATED WITH INVALID DATA**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1456**	**PENDING IME ROOM & BOARD CHANGES FOR SUD. REPROCESS ON APPVL**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1457**	**PEND ALL CLAIMS FOR PROCEDURE CODE 97127HI**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1460**	**CMS PROC CODE MAINTENANCE. REPROCESS ON APPROVAL**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1461**	**INCORRECT SUBMITTER ID FOR EVV SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1462**	**INCORRECT SUBMITTER ID FOR EVV SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1633**	**PA REQUIRED FOR PARTIAL CARE**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1635**	**ORIGINAL APPRP CODE NOT IN USE, FIELD UPDATED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1671**	**SERVICE DATE/HCPCS COMBINATION MATCH OCCURRENCE IN HISTORY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1707**	**COVID VACCINE ADMINISTRATION CONFLICT**	175 (03/01/21)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1708**	**MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES**	175 (03/01/21)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**1711**	**SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES**	119 (07/01/22)	Benefit maximum for this time period or occurrence has been reached.

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2138**	**ANONYMOUS NALOXONE BUDGET LIMIT EXCEEDED FOR THE FY**	175 (12/13/22)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2279**	**CLAIM SERVICE DATE OCCURS DURING DISASTER SITUATION**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2286**	**FACILITY ID NPI IS NOT NUMERIC OR CHECK DIGIT IS INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2287**	**FACILITY ID NPI NOT VALID ON NPPES PROVIDER DATABASE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2288**	**FACILITY NPI CANNOT BE MAPPED TO A MEDICAID ID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2289**	**FACILITY ID NPI MAPS TO A NON-LTC MEDICAID PROVIDER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2327**	**450-EF COMPOUND DOSAGE FORM DESCRIPTION CODE IS INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2331**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II-V**	175 (09/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2332**	**DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2333**	**460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2334**	**QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2335**	**QTY DISPENSED > QTY PRESCRIBED**	175 (09/20/20)	Prescription is incomplete.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2336**	**NUM OF REFILLS AUTH > O SCHED II**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2337**	**403-3D FILL NUMBER M/I**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2338**	**403-D3 NUMBER > O ON SCHED II**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2340**	**343-HD DISPENSING STATUS INVALID**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2342**	**ACCUM OF MED EXCEEDS 30 DAYS SUPPLY**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2343**	**NDC PRICING EXCEEDS CLASS AVG; CHANGE NDC OR PA NEEDED**	204 (11/20/20)	This service/equipment/drug is not covered under the patient's current benefit plan
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2350**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II - V**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2351**	**OTC COVID TEST EXCEEDED- LIMIT 4 KITS PER MONTH**	175 (02/28/22)	Prescription is incomplete.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2354**	**PAAD RECIPIENT W/ ADDP ELIGIBILITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2355**	**SENIOR GOLD RECIPENT W/ADDP ELIGIBILITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2356**	**MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2357**	**SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**2360**	**OTC PREGNANCY TEST LIMIT - 1 PKG/CLAIM, 4 CLAIMS/30 DAYS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA131 (01/01/14)	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.	**0962**	**ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA134 (11/01/15)	Missing/incomplete/invalid provider number of the facility where the patient resides.	**0010**	**INVALID SERVICING PROVIDER MEDICAID ID NUMBER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.	**0312**	**CORRECT RECIPIENT NUMBER AND RESUBMIT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA27 (12/01/14)	Missing/incomplete/invalid entitlement number or name shown on the claim.	**1345**	**RESUBMIT CLAIM WITH ELIGIBLE MEDICAID RECIPIENT ID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	**0051**	**RENAL REVENUE IS PRESENT - RENAL BILL TYPE IS MISSING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	**0054**	**INPATIENT/INPATIENT CROSSOVER CLAIM - SWING BEDS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	**0123**	**EMC CLM NOT ALLOWED FOR SR GOLD CLM SUBMIT BY POS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	**0190**	**1ST 2 POSITIONS OF BILL TYPE CONFLICTS WITH THE PAYOR ID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (10/16/03)	Missing/incomplete/invalid type of bill.	**0435**	**UNABLE TO DETERMINE HIPAA CLAIM TYPE.**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0022**	**INV/MISS BILLED DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0041**	**ADMISSION DATE > SERVICE COVERS FROM DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0057**	**CONDITION CODE 40 - FROM/THRU NOT EQUAL**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0064**	**SERVICE THRU DATE > STATEMENT THRU DATE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0073**	**SERVICE COVERS FROM DATE < STATEMENT FROM DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0074**	**STATEMENT COVERS FROM DATE > SERVICE THRU DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0089**	**DATE OF SURGERY > SERVICE/STATEMENT THRU DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0111**	**LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0113**	**LTC/HOSPICE LONG TERM PSYCH CLAIM SPANS MONTHS'**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0220**	**CLAIM SPANS FISCAL YEAR**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0334**	**DATE OF CONS MUST BE AT LEAST 30 BUT NOT > 180 DAYS FROM DOS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0401**	**DATE OF SERVICE < DATE OF BIRTH**	14 (10/16/03)	The date of birth follows the date of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0530**	**LTC OVERLAPPING LEAVE PERIODS**	226 (01/01/14)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**0620**	**RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK**	141 (01/01/14)	Claim spans eligible and ineligible periods of coverage.
MA31 (09/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**1408**	**HOSPICE CUTBACK DAY OF REVOCATION**	238 (09/01/14)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
MA31 (06/29/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**1409**	**HOSPICE DATE OF DEATH PAYMENT CUTBACK**	238 (06/29/15)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
MA31 (01/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**1640**	**HOSPICE TRANSFER DAY OF DISCHARGE PAYMENT CUTBACK**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.	**0157**	**ACUTE DAYS > 150 - RESUBMIT AS INPATIENT TPL CLAIM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.	**0158**	**ACUTE DAYS > 90 - RESUBMIT AS INPATIENT TPL CLAIM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA33 (10/16/03)	Missing/incomplete/invalid non-covered days during the billing period.	**0067**	**INV/MISS NON COVERED HOSPITAL DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	**0173**	**INVALID COINSURANCE DAYS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	**0179**	**MISSING/INVALID COINSURANCE DAYS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.	**0510**	**COINS DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA34 (11/01/15)	Missing/incomplete/invalid number of coinsurance days during the billing period.	**1252**	**MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.	**0154**	**COINS AND/OR LIFETIME RESERVE DAYS CONFLICT WITH DOS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.	**0155**	**COINS DAYS LIFETIME RESERVE DAYS AND/OR BLD DEDUCT MISSING**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA35 (11/01/15)	Missing/incomplete/invalid number of lifetime reserve days.	**0156**	**COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA36 (10/16/03)	Missing/incomplete/invalid patient name.	**0012**	**MISSING RECIPIENT NAME**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA36 (01/01/14)	Missing/incomplete/invalid patient name.	**0302**	**NAME MISMATCH OR FOR PHARMACY: GENDER AND/OR DOB**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA36 (01/01/14)	Missing/incomplete/invalid patient name.	**1205**	**ADJUSTMENT/VOID DOES NOT MATCH RECIPIENT ID ON CLAIM**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA39 (06/18/07)	Missing/incomplete/invalid gender.	**1803**	**CLAIM CHECK: INVALID OR MISSING GENDER**	7 (12/12/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA39 (11/01/15)	Missing/incomplete/invalid gender.	**1829**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (10/16/03)	Missing/incomplete/invalid admission date.	**0040**	**INV/MISS ADMISSION DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (11/01/15)	Missing/incomplete/invalid admission date.	**0515**	**NURSING FACILITY ADMIT RESTRICTED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA40 (10/16/03)	Missing/incomplete/invalid admission date.	**0635**	**LTC NEW ADMIT DATE OF SERVICE PRIOR TO ASSESSMENT DATE**	26 (10/16/03)	Expenses incurred prior to coverage.
MA41 (10/16/03)	Missing/incomplete/invalid admission type.	**0044**	**INV/MISS TYPE OF ADMISSION**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA42 (10/16/03)	Missing/incomplete/invalid admission source.	**0068**	**INVALID SOURCE OF ADMISSION**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA42 (10/16/03)	Missing/incomplete/invalid admission source.	**0084**	**BABY & MOTHER-ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (11/01/15)	Missing/incomplete/invalid patient status.	**0001**	**GENERIC ELIGIBILITY RECORD USED.**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	**0045**	**INV/MISS PATIENT STATUS CODE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	**0367**	**GA RECIPIENT INELIGIBLE ON DATE OF SERVICE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	**0419**	**WFNJ/GA OR NJFL CLAIM PROCESSED AS ADDP**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	**0420**	**CLAIM PAYABLE UNDER WFNJ/GA OR FC ONLY**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA43 (01/01/14)	Missing/incomplete/invalid patient status.	**1654**	**RECIPIENT INELIGIBLE FOR ACA TITLE 19**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.	**0346**	**INVALID/MISSING STERILIZATION INTERPRETER INDICATOR**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.	**0347**	**INVALID/MISS STERILIZATION RACE CODE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA61 (11/01/15)	Missing/incomplete/invalid social security number.	**0398**	**GA RECIPIENT ID CHANGED TO MEDICAID RECIPIENT ID.**	31 (11/01/15)	Patient cannot be identified as our insured.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA63 (11/01/15)	Missing/incomplete/invalid principal diagnosis.	**0294**	**DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.	**0919**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ**	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.
MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.	**0920**	**DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA**	146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.
MA64 (11/01/15)	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	**1645**	**HMS MEDICARE COVERAGE IS NOT PRESENT ON TPL**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA64 (11/01/15)	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	**1646**	**HMS PRIVATE COVERAGE IS NOT PRESENT ON THE TPL**	22 (11/01/15)	This care may be covered by another payer per coordination of benefits.
MA65 (10/16/03)	Missing/incomplete/invalid admitting diagnosis.	**0114**	**INV/MISS ADMIT CODE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA65 (11/01/15)	Missing/incomplete/invalid admitting diagnosis.	**1288**	**INVALID/MISSING UB04 ADMIT DIAGNOSIS**	47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**0161**	**INV/MISS HCPCS PROCEDURE CODE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**0248**	**SURGERY PROCEDURE CODE NOT ON FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**0345**	**MISSING ABORTION PROCEDURE CODE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (11/01/15)	Missing/incomplete/invalid principal procedure code.	**0666**	**UNABLE TO PRICE CLAIM**	107 (11/01/15)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA67 (05/04/21)	Alert: Correction to a prior claim.	**1466**	**REPROCESSED AT THE REQUEST OF MFD - WITHOUT A UD MODIFIER**	129 (05/04/21)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
MA67 (03/20/23)	Alert: Correction to a prior claim.	**1470**	**RECYCLED AFTER CHANGE OF OWNERSHIP - ALM 3708**	129 (03/20/23)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA67 (06/08/15)	Alert: Correction to a prior claim.	**1674**	**REPROCESS PE CLAIMS NOW ELIGIBLE FOR NEW ADULT GROUP**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA70 (01/01/14)	Missing/incomplete/invalid provider representative signature.	**0360**	**PHYSICIAN SIGNATURE/DATE MISSING ON SECOND OPINION FORM**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA71 (11/01/15)	Missing/incomplete/invalid provider representative signature date.	**0356**	**RECIP/PHYS DATE/SIGN MISSING ON STERILIZATION FORM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA75 (01/01/14)	Missing/incomplete/invalid patient or authorized representative signature.	**0342**	**RECIPIENT DATES, SIGNATURE MISSING ON HYSTER FORM**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0917**	**MODERATE DRUG/DRUG INTERACTION DUR**	188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0918**	**DAILY DOSAGE EXCEEDS MAXIMUM RECOMMENDED DOSAGE**	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0921**	**SEVERE DRUG/DRUG INTERACTION - NO PA OVERRIDE CAPABILITY**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0922**	**DRUG INDICATES PREGNANCY PRECAUTION WARNING**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0923**	**DAILY DOSAGE LESS THAN MINIMUN RECOMMENDED DOSAGE**	11 (10/16/03)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0941**	**SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM**	3 (10/16/03)	Co-payment Amount
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**0987**	**DEDUCT AMT INCLUDES MEDICARE OR PRIVATE INS REFUND TO STATE**	B10 (10/16/03)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
MA80 (04/01/18)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**1625**	**COMMERCIAL HMO CO-PAY/COINS/DEDUCT**	3 (04/01/18)	Co-payment Amount
MA81 (01/01/14)	Missing/incomplete/invalid provider/supplier signature.	**0344**	**PHYSICIAN SIGN/NUMBER/DATES MISSING ON ABORTION FORM**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA92 (09/01/20)	Missing plan information for other insurance.	**0443**	**TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA92 (01/01/14)	Missing plan information for other insurance.	**0946**	**RA SHOWING MEDICAID CROSSOVER PAYMENT MUST BE ATTACHED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	**0325**	**SERVICE NOT COVERED BY HMO - RECIPIENT INELIG FOR MEDICAID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	**0328**	**MHC RECIPIENT-NO M'CAID ELIG SEGMENT FOR THIS PERIOD**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	**0330**	**HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	**0508**	**PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N3 (01/01/16)	Missing consent form.	**0196**	**TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER**	163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.
N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0171**	**INVALID CARRIER CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0943**	**REBILL CLAIM WITH MEDICARE PAID LINES ONLY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0947**	**MEDICARE OUTPATIENT PART B EOB MISSING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0948**	**EOB MISSING FOR CARRIER/PAYOR REPORTED ON CLAIM**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0959**	**CLAIM UPDATED WITH TPL PAYMENT**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0965**	**MEDICARE INPATIENT PART A EOB MISSING**	252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0966**	**MEDICARE INPATIENT PART B EOB MISSING**	252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0967**	**MEDICARE PHYSICIAN PART B EOB MISSING**	252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0971**	**MISSING CARRIER CODE/PAYOR ID**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0972**	**NO EOB ATTACHED-RECIPIENT WITH OTHER RESOURCE INDICATED**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0973**	**CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.
N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0974**	**TPL PAYMENT AMOUNT FROM EOB MISSING ON CLAIM**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0980**	**EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM**	163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0982**	**EOB INDICATES BILLING ERROR, REVIEW OR REBILL TO CARRIER**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	**0985**	**ENTER TPL AMT PAID FROM EOB IN PRIOR PMT BOX ON CLAIM FORM**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N5 (08/31/04)	EOB received from previous payer. Claim not on file.	**0799**	**NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N8 (10/16/03)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	**0174**	**CLAIM IS NOT XOVER - RESUBMIT AS INPATIENT HOSPITAL CLAIM**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N8 (11/01/15)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	**1636**	**MEDICARE CROSSOVER CLAIM PAID AND DUPLICATE DME CLAIM VOIDED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.	**0798**	**HISTORY RECORD ALREADY ADJUSTED OR VOIDED**	129 (10/16/03)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N9 (11/29/21)	Adjustment represents the estimated amount a previous payer may pay.	**1038**	**PROVIDER NOT COVERED FOR OORP SERVICES**	96 (11/29/21)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0234**	**PEND FOR OUT-OF-STATE NON-DRG PRICING POLICY CHANGE**	55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0458**	**OCCURRENCE CODE INDICATES ACCIDENT REVIEW REQUIRED**	55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0550**	**PENDING FOR REVIEW OF DRUG FILE ENTRY**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0605**	**OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING**	40 (04/01/18)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0608**	**PEND FOR MANUAL PRICING**	40 (11/01/15)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0617**	**CALCULATED PAYMENT AMOUNT ZERO**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0710**	**UNABLE TO DETERMINE LEAVE PERIOD-ADJUSTMENT MAY BE REQUIRED**	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0732**	**ADJUSTMENT TO DENTURES WITHIN 6 MONTHS OF DELIVERY**	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0788**	**ADJUSTMENT DENIED/ORIG PAID CORRECTLY**	B20 (11/01/15)	Procedure/service was partially or fully furnished by another provider.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0790**	**INVALID ADJUSTMENT LOCATOR**	96 (01/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0791**	**ADJUSTMENT REQUIRES MANUAL UPDATE**	151 (09/01/20)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0792**	**ADJUSTMENT TO CONVERTED CLAIM**	150 (01/01/16)	Payer deems the information submitted does not support this level of service.
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0793**	**ADJUSTMENT PENDED FOR ARCHIVE CYCLE**	151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0844**	**ADJUSTMENT CLAIM MISSING PAYOR CODE AND/OR PRIOR PAYMENT**	65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.
N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**0846**	**ADJUSTMENT MUST HAVE RA ATTACHED**	65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**1202**	**PREMIUM SUPPORT PROGRAM - STATE REVIEW REQUIRED.**	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**1279**	**CALCULATED PAYMENT AMOUNT ZERO**	150 (11/01/15)	Payer deems the information submitted does not support this level of service.
N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**1603**	**ADJ/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIG**	51 (01/01/16)	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	**1629**	**DENTAL ANESTHESIA CLAIM CUTBACK BY BEHAVIOR MANAGEMNT CLAIMS**	269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N12 (11/01/15)	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	**0285**	**HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0601**	**PAYMENT REDUCED TO MEDICAID MAXIMUM**	35 (01/01/14)	Lifetime benefit maximum has been reached.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0626**	**PAYMENT REDUCED TO MAC MAXIMUM**	B5 (01/01/14)	Coverage/program guidelines were not met or were exceeded.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0630**	**LTC LEAVE DAYS CUT BACK TO MAXIMUM ALLOWED**	45 (03/25/15)	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0637**	**MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS**	22 (01/01/14)	This care may be covered by another payer per coordination of benefits.
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0656**	**MISSING NJ DRG MARKUP FACTOR**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**0882**	**ORTHODONTIC CUTBACK/INITIAL PAYMENT**	23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
N19 (01/01/14)	Procedure code incidental to primary procedure.	**0906**	**MULTIPLE SURGERY - $0 PAID, INCIDENTAL PROCEDURE**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N20 (11/01/15)	Service not payable with other service rendered on the same date.	**0778**	**NO IMMUNIZATION CODE PROVIDED ON THE SAME DAY OF SERVICE**	16 (07/23/04)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	**0392**	**PROCEDURE CODE MAPPED TO LOCAL CODE FOR PROCESSING PURPOSES**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	**0968**	**PROCEDURE CODE DOES NOT ACCURATELY REFLECT SERVICES RENDERED**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N26 (01/29/16)	Missing itemized bill/statement.	**0957**	**CLAIM CORRECTED OR REPROCESSED BY REQUEST**	250 (01/29/16)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N27 (11/01/15)	Missing/incomplete/invalid treatment number.	**0101**	**ABNOR INDIC IN THE PHYS/SCR IND NEW/PRIOR COND INVAL/MISS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N27 (11/01/15)	Missing/incomplete/invalid treatment number.	**0348**	**INVALID ABORTION CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N28 (11/01/15)	Consent form requirements not fulfilled.	**0353**	**ATTACHED FORM DATA INCORRECT/MISSING/ILLEGIBLE**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N29 (10/16/03)	Missing documentation/orders/notes/summary/report/chart.	**0996**	**NO APPROP CODES ASSIGNED FOR CREDIT RECORD**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N30 (10/16/03)	Patient ineligible for this service.	**0263**	**NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0301**	**RECIPIENT INELIG ON DATES OF SERVICE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	**0305**	**CCPED OR HCEP NON COVERED SERVICE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (09/01/20)	Patient ineligible for this service.	**0308**	**INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (01/01/14)	Patient ineligible for this service.	**0309**	**GSHP OUT-OF-PLAN SERVICE- RECIPIENT INELIGIBLE FOR MEDICAID**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/01/15)	Patient ineligible for this service.	**0332**	**STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21**	167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0350**	**GENERAL ASSISTANCE-SERVICE NOT COVERED.**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0365**	**GA RECIPIENT NOT ON RECIP HISTORY MASTER FILE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/03/03)	Patient ineligible for this service.	**0370**	**PLAN H - BENEFICIARY - NON-COVERED SERVICE.**	96 (11/04/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/01/15)	Patient ineligible for this service.	**0371**	**CSOCI - UNABLE TO DETERMINE COVERAGE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0373**	**CSOCI - NON-COVERED SERVICE**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (10/16/03)	Patient ineligible for this service.	**0385**	**NON-COVERED SERVICE FOR PROGRAM STATUS CODE**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/01/15)	Patient ineligible for this service.	**0399**	**GA RECIPIENT ID CHANGED.**	26 (11/01/15)	Expenses incurred prior to coverage.
N30 (10/16/03)	Patient ineligible for this service.	**0432**	**THIS LEGEND DRUG NOT COVERED BY PAAD/SG**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0450**	**DRUG NOT COVERED FOR ESRD RECIPIENT**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0451**	**MEDICAL SUPPLY OR SERVICE(S) NOT COVERED FOR ESRD RECIPIENT**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0456**	**LAB NOT COVERED FOR ESRD RECIPIENT**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	**0506**	**RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES**	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N30 (11/01/15)	Patient ineligible for this service.	**0521**	**RECIP NOT ON LTC MASTER FILE**	26 (11/01/15)	Expenses incurred prior to coverage.
N30 (11/01/15)	Patient ineligible for this service.	**0525**	**LTC PASARR APPROVAL TERMINATED**	27 (11/01/15)	Expenses incurred after coverage terminated.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (11/01/15)	Patient ineligible for this service.	**0528**	**LTC RECIP NOT ELIG FOR ENTIRE PERIOD-CUTBACK ASSESSMENT DTE**	27 (11/01/15)	Expenses incurred after coverage terminated.
N30 (10/16/03)	Patient ineligible for this service.	**0532**	**NON LEGEND DRUG NOT COVERED FOR PAAD/SR GOLD BENEFICIARIES**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0534**	**DRUG NOT PAYABLE FEDERAL/IRS DESI**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0552**	**ADDP-SERVICE NOT COVERED.**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (10/16/03)	Patient ineligible for this service.	**0555**	**PAAD RECIP INELIGIBLE FOR MEDICAID SERVICES**	150 (10/16/03)	Payer deems the information submitted does not support this level of service.
N30 (10/16/03)	Patient ineligible for this service.	**0561**	**COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (01/01/14)	Patient ineligible for this service.	**0581**	**DENTAL SERVICES AFTER ELIGIBILITY TERMINATION**	27 (01/01/14)	Expenses incurred after coverage terminated.
N30 (10/01/19)	Patient ineligible for this service.	**1011**	**NOT A FAMILY PLANNING SVC/NOT ATTESTED PLANNING SVC**	204 (10/01/19)	This service/equipment/drug is not covered under the patient's current benefit plan
N30 (10/01/08)	Patient ineligible for this service.	**1318**	**DOC RECIPIENT INELIG ON DATE OF SERVICE**	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N30 (10/01/08)	Patient ineligible for this service.	**1319**	**DOC RECIPIENT NOT ON FILE**	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.

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N30 (05/15/17)	Patient ineligible for this service.	**1447**	**RECIPIENT INELIGIBLE FOR CSOC RESPITE SERVICE**	96 (05/15/17)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N30 (11/10/14)	Patient ineligible for this service.	**2290**	**PHARMACY CLAIM NOT PAYABLE FOR SPC 98 OR 99**	258 (01/29/16)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N31 (01/01/14)	Missing/incomplete/invalid prescribing provider identifier.	**0004**	**INV/MISS PRESCRIBER'S MEDICAID ID NUMBER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	**1233**	**NPI MISSING FOR PRESCRIBING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	**1267**	**NPI NOT CROSSWALKED - PRESCRIBING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	**1268**	**PROVIDER NOT MATCHED-PRESCRIBING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N31 (05/09/11)	Missing/incomplete/invalid prescribing provider identifier.	**1309**	**SUPERVISING PROVIDER NOT ON FILE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (01/01/13)	Missing/incomplete/invalid prescribing provider identifier.	**1387**	**PROVIDER ID AND NPI REQUIRED - PRESCRIBING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.	**1413**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - PRESCRIBING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.	**1423**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - PRESCRIBING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (01/01/19)	Missing/incomplete/invalid prescribing provider identifier.	**2298**	**SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N32 (11/01/15)	Claim must be submitted by the provider who rendered the service.	**0522**	**INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N32 (06/18/07)	Claim must be submitted by the provider who rendered the service.	**1862**	**CLAIM CHECK: MISSING PROVIDER ON CLAIM**	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	**0288**	**VETERANS HOME RESIDENT, NON COVERED SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	**0340**	**ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (01/01/14)	Incorrect claim form/format for this service.	**0357**	**HYSTERECTOMY RECEIPT OF INFO FORM-DATA INCORR/MISS OR ILLEG**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N34 (11/01/15)	Incorrect claim form/format for this service.	**0944**	**PROCEDURE CODE AND/OR CHARGES ON CLAIM DO NOT MATCH EOB**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N34 (11/01/15)	Incorrect claim form/format for this service.	**0998**	**INCORRECT PAAD CLAIM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	**0223**	**PROVIDER ON REVIEW-DENY PAYMENT**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	**0280**	**POS PAID CLAIM, PAYMENT PENDING**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	**0315**	**HOSPICE ELECTION REVIEW**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	**0316**	**LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N35 (10/16/03)	Program integrity/utilization review decision.	**0375**	**SPECIAL STATE AUTO PEND**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	**0379**	**SPEC PGM UNABLE TO DETERMINE COVERAGE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (11/01/15)	Program integrity/utilization review decision.	**0426**	**NO FQHC ENCOUNTER WITH DELIVERY HCPCS CLAIM PAID AT NON-ZERO**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	**0651**	**MISSING PENNSYLVANNIA DRG RATE DATA**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N35 (10/16/03)	Program integrity/utilization review decision.	**0652**	**MISSING NEW YORK DRG RATE DATA**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N35 (10/16/03)	Program integrity/utilization review decision.	**0653**	**MISSING NY DRG SERVICE INTENSITY WEIGHT**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N35 (10/16/03)	Program integrity/utilization review decision.	**0654**	**MISSING NY DRG OUTLIER PERCENT**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).

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N35 (10/16/03)	Program integrity/utilization review decision.	**0655**	**MISSING NEW YORK DRG ALC PER DIEM RATE**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
N35 (10/16/03)	Program integrity/utilization review decision.	**0888**	**CLAIM VOIDED DUE TO STATE AUDIT - SEE REMITTANCE MESSAGE 624**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
N35 (01/01/14)	Program integrity/utilization review decision.	**0925**	**UTILIZATION REVIEW APPROVAL MISSING/INCORRECT/DENIED**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N35 (10/16/03)	Program integrity/utilization review decision.	**0942**	**CLAIM VOIDED DUE TO POST-PAYMENT REVIEW BY MUNICIPALITY.**	A1 (10/16/03)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N36 (11/01/15)	Claim must meet primary payer's processing requirements before we can consider payment.	**0391**	**PREMIUM SUPPORT - BILL OTHER INSURANCE**	109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N37 (11/01/15)	Missing/incomplete/invalid tooth number/letter.	**0587**	**MISSING/INVALID TOOTH NUMBER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	**0116**	**INVALID LEAVE OF ABSENCE DATE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	**0117**	**LEAVE OF ABSENCE DATE(S) OUTSIDE DATES OF SERVICE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N43 (10/16/03)	Bed hold or leave days exceeded.	**0118**	**LEAVE OF ABSENCE FROM/THRU DATE CONFLICT**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	**0121**	**MCARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (10/16/03)	Bed hold or leave days exceeded.	**0122**	**MCARE BED HOLD END DATE OUTSIDE DATES OF SERVICE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (11/01/15)	Bed hold or leave days exceeded.	**0509**	**MEDICARE BED HOLD INVALID**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	**0718**	**HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	**0719**	**THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/16)	Bed hold or leave days exceeded.	**0833**	**CLAIM FOR CONTINUOUS LEAVE- NO PRIOR SERVICE DATE PAID CLAIM**	96 (01/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N43 (01/01/14)	Bed hold or leave days exceeded.	**0930**	**BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	**0932**	**THERAPEUTIC LEAVE EXCEEDS MAXIMUM OF 24 CONSECUTIVE DAYS**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (11/01/15)	Bed hold or leave days exceeded.	**0933**	**THERAPEUTIC LEAVE CUTBACK TO 24 DAYS MAXIMUM**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (01/01/14)	Bed hold or leave days exceeded.	**0934**	**BED-HOLD CUTBACK TO 10 DAY MAXIMUM**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N43 (07/01/07)	Bed hold or leave days exceeded.	**1248**	**NO BED HOLD/THERAPEUTIC LEAVE PAYMT FOR NURSING FACILITY**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N45 (11/01/15)	Payment based on authorized amount.	**0289**	**PAYMENT BASED ON THE PLACE OF SERVICE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N45 (10/16/03)	Payment based on authorized amount.	**0526**	**PA-3L INCOME GREATER THAN PATIENT PAYMENT AMOUNT PA-3L USED**	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.

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N45 (01/01/08)	Payment based on authorized amount.	**1258**	**SERVICES PAID AT CHILDREN'S RATE**	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N45 (11/01/15)	Payment based on authorized amount.	**1335**	**PAYMENT REDUCED TO SUL PRICE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N45 (04/01/17)	Payment based on authorized amount.	**2297**	**CLAIM SUBMITTED AS A 340B CLAIM**	119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.
N46 (10/16/03)	Missing/incomplete/invalid admission hour.	**0063**	**INV/MISS ADMISSION HOUR**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N46 (09/07/10)	Missing/incomplete/invalid admission hour.	**1286**	**INVALID UB04 OCCURRENCE SPAN THRU DATE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N48 (01/01/14)	Claim information does not agree with information received from other insurance carrier.	**0787**	**ADJUSTMENT CLAIM TYPE NOT MATCHED**	129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N50 (10/16/03)	Missing/incomplete/invalid discharge information.	**0115**	**INVALID GENERAL STATUS / DISCHARGE CODE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N50 (10/16/03)	Missing/incomplete/invalid discharge information.	**0119**	**INV/MISS LEAVE OF ABSENCE CODE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N50 (10/16/03)	Missing/incomplete/invalid discharge information.	**0514**	**NURSING FACILITY LEAVE/RETURN RESTRICTED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.	**0600**	**LTC RECIPIENT NOT ELIGIBLE ON DATE(S) OF SERVICE**	26 (11/01/15)	Expenses incurred prior to coverage.
N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.	**1381**	**ACTIVE MANAGED CARE FOUND W/O ACTIVE ELIGIBILITY**	256 (11/01/15)	Service not payable per managed care contract.
N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.	**0410**	**SERVICE NOT AUTHORIZED BY GSHP CASE MANAGER**	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.	**0776**	**PA DOLLARS/UNITS EXHAUSTED-CUTBACK**	198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.	**0784**	**GSHP PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED**	198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.
N54 (01/01/14)	Claim information is inconsistent with pre-certified/authorized services.	**1600**	**CLAIM EXCEEDS BEDS LICENSED TO PROVIDER FOR THE MONTH**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.	**1617**	**PA NUMBER CHANGED SYSTEMATICALLY**	198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N55 (09/10/13)	Procedures for billing with group/referring/performing providers were not followed.	**0993**	**CLAIM DENIED AT PROVIDER REQUEST**	P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0048**	**MISSING/INV SURGICAL PROCEDURE CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0150**	**INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON 1500NJ**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0163**	**PROCEDURE - SPANNING DATES OF SERVICE**	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0238**	**PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0247**	**REVENUE/ICD9/HCPCS PROC CODE ON CLM CONFLICTS WITH CLM TYPE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0273**	**PROCEDURE DOES NOT WARRANT SURGICAL ASSIST**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0584**	**MODIFIER REMOVED - TRIP LESS THAN 16 MILES**	4 (10/16/03)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**0724**	**DATE(S) OF SERVICE DO NOT MATCH LAB PANEL PROCEDURE EFF DATE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N56 (01/01/16)	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**1438**	**HOSPICE SERVICE INTENSITY ADD-ON LIMIT EXCEEDED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N57 (10/16/03)	Missing/incomplete/invalid prescribing date.	**0025**	**INV/MISS DISPENSED DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N58 (11/01/15)	Missing/incomplete/invalid patient liability amount.	**0136**	**COPAY CLAIM DENIED - NO BENEFICIARY OR PROGRAM LIABILITY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N58 (09/01/20)	Missing/incomplete/invalid patient liability amount.	**0698**	**COINSURANCE DAYS EXCEED MEDICARE MAXIMUM OF 30 DAYS**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**0300**	**HMO-COVERED SERVICE**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	**0413**	**2 PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**	153 (10/16/03)	Payer deems the information submitted does not support this dosage.
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	**0414**	**1 PRESCRIPTION REMAINS WITHOUT NEED FOR PRIOR AUTHORIZATION**	153 (10/16/03)	Payer deems the information submitted does not support this dosage.
N59 (04/01/18)	Alert: Please refer to your provider manual for additional program and provider information.	**0415**	**NO PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION**	153 (04/01/18)	Payer deems the information submitted does not support this dosage.
N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.	**0539**	**THIS LIVERY SVC IS ONLY VALID IN COUNTIES 07, 09 AND 90**	A1 (10/16/03)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**0571**	**CAPITATION INDICATOR NOT MATCHED**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**0572**	**INVALID CAP CODE**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**0662**	**CLAIM PRICED-CHARGE TO MCAID AS PERCENT OF TOTAL CLM CHARGE**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**1021**	**CAPITATION PAYMENT REDUCED BY FULL PATIENT LIABILITY**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**1024**	**CAPITATION PAYMENT REDUCED BY PARTIAL PATIENT LIABILITY**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**1026**	**CAPITATION PAYMENT REDUCED FOR ELIGIBILITY LIMITS**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.	**1380**	**GHI CROSSOVER - SERVICE IS IN-PLAN (MANAGED CARE)**	24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.
N61 (11/01/15)	Rebill services on separate claims.	**0319**	**INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N61 (11/01/15)	Rebill services on separate claims.	**0908**	**UNABLE TO PRICE MULTIPLE SURGERY CLAIM**	267 (11/01/15)	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N62 (01/01/14)	Dates of service span multiple rate periods. Resubmit separate claims.	**0284**	**PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N62 (11/01/15)	Dates of service span multiple rate periods. Resubmit separate claims.	**1209**	**DOS SPANS PROVIDER FISCAL YR, MULTIPLE RATE USED FOR PRICING**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N62 (01/01/16)	Dates of service span multiple rate periods. Resubmit separate claims.	**1443**	**HOSPICE DOS OVERLAP THE FIRST 60 DAYS OF HOSPICE CARE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N63 (11/01/15)	Rebill services on separate claim lines.	**0642**	**RESUBMIT CLM WITH INVOICE OR MANUFACTURER'S PRICE LIST**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (04/01/18)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0533**	**OTC DRUG COST INCLUDED IN NF PER DIEM**	107 (04/01/18)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0565**	**OTC DRUG NO UNIT PRICE ON FILE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0566**	**OTC DRUG NO PACKAGE PRICE ON FILE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0567**	**TEAMCARE DRUG NO UNIT PRICE ON FILE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0568**	**TEAMCARE DRUG NO PACKAGE PRICE ON FILE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0569**	**LEGEND DRUG NO PACKAGE PRICE ON FILE**	107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0574**	**CAPITATION RATE NOT FOUND FOR CLAIM DOS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0575**	**NO GSHP PCM RATE NOT FOUND FOR CLAIM SERVICE DATE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0591**	**PROVIDER NOT ON PROVIDER RATE FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0592**	**CAPITATION CATEGORY NOT ON GSHP RATE FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0593**	**CAPITATION CATEGORY RATE NOT IN EFFECT FOR DATE OF SERVICE**	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0595**	**REV CODE/COND CODE CONFLICT FOR COMPOSITE RATE PRICING**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0596**	**PHARMACY CAPITATION RATE LEVEL NOT IN EFFECT FOR DOS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0618**	**VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE**	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**0619**	**VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE**	147 (10/16/03)	Provider contracted/negotiated rate expired or not on file.
N75 (01/01/14)	Missing/incomplete/invalid tooth surface information.	**0102**	**INV/MISS TOOTH SURFACE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N75 (10/16/03)	Missing/incomplete/invalid tooth surface information.	**0582**	**MISSING/INVALID TOOTH SURFACE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N75 (11/01/15)	Missing/incomplete/invalid tooth surface information.	**0586**	**MISSING/INVALID TOOTH QUADRANT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N77 (11/01/15)	Missing/incomplete/invalid designated provider number.	**0217**	**LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD:CUTBACK**	208 (11/01/15)	National Provider Identifier - Not matched.
N77 (11/01/15)	Missing/incomplete/invalid designated provider number.	**0579**	**PROVIDER IRS NUM REQUIRED FOR SPECIAL EDUC CLAIM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N77 (08/16/10)	Missing/incomplete/invalid designated provider number.	**1329**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	208 (08/16/10)	National Provider Identifier - Not matched.
N77 (08/16/10)	Missing/incomplete/invalid designated provider number.	**1334**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	208 (08/16/10)	National Provider Identifier - Not matched.
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0092**	**INV/MISS EPSDT IMMUNIZATION STATUS CODE(S)**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0093**	**INV/MISS EPSDT SCREENING INFORMATION INDICATORS**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0094**	**INV/MISS OR CONFLICTING EPSDT PHYSICAL DATA INDICATOR**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0095**	**INV/MISS EPSDT RACE CODE**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0096**	**EPSDT ANTICIPATORY GUIDANCE MISSING OR INVALID**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0097**	**INVALID EPSDT PHYSICAL SCREEN INDICATOR**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0098**	**INVALID OR MISSING EPSDT CONTINUED CARE**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**0099**	**EPSDT WIC INDICATOR INVALID OR MISSING**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	**0202**	**PROVIDER CANNOT SUBMIT THIS CLAIM TYPE**	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	**0219**	**PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION**	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	**0221**	**PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE**	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**0226**	**BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE**	243 (11/01/15)	Services not authorized by network/primary care providers.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**0229**	**SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO.OR MORE**	243 (11/01/15)	Services not authorized by network/primary care providers.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	**0237**	**PROCEDURE/PROVIDER SPECIALTY RESTRICTION**	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	**0266**	**NOT AN SAI COVERED SERVICE**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	**0278**	**PROVIDER NOT AUTHORIZED THIS PROCEDURE**	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	**0380**	**CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)**	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (10/16/03)	This provider type/provider specialty may not bill this service.	**0381**	**CLAIM SUBMITTED FFS-UNABLE TO DETERMINE IN-PLAN/OUT-OF-PLAN**	8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/31/04)	This provider type/provider specialty may not bill this service.	**0590**	**PROC CODE BILLED IS ONLY PAYABLE TO A SPECIALIST**	8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (01/28/05)	This provider type/provider specialty may not bill this service.	**0690**	**PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM.**	242 (01/01/14)	Services not provided by network/primary care providers.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**0697**	**CLAIM PENDED PROVIDER RE-ENROLLMENT NOT COMPLETED**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (04/02/10)	This provider type/provider specialty may not bill this service.	**1326**	**INVALID PROVIDER TYPE FOR ATTENDING PROVIDER**	170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N95 (07/01/09)	This provider type/provider specialty may not bill this service.	**1327**	**HMO RESPONSIBLE FOR NON-ABP FACILITY COSTS**	256 (11/01/15)	Service not payable per managed care contract.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**1338**	**ESRD BILLABLE SERVICE**	256 (11/01/15)	Service not payable per managed care contract.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**1383**	**INVALID PROVIDER TYPE - OPERATING 1**	170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**1384**	**INVALID PROVIDER TYPE - OPERATING 2 PHYSICIAN**	170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (02/01/16)	This provider type/provider specialty may not bill this service.	**1385**	**PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - SERVICING**	170 (02/01/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (02/01/16)	This provider type/provider specialty may not bill this service.	**1386**	**PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - BILLING**	52 (01/01/13)	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
N95 (02/20/17)	This provider type/provider specialty may not bill this service.	**1452**	**NON-MEDICAID PROVIDER NOT ELIGIBLE FOR SERVICE**	170 (02/20/17)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (06/26/17)	This provider type/provider specialty may not bill this service.	**1453**	**INCORRECTLY BILLED SVC; REQUIRES HH MOD, CCBHC SVC/PROV**	96 (06/26/17)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (08/06/18)	This provider type/provider specialty may not bill this service.	**1455**	**NOT A COVERED SERVICE UNDER NJ MEDICAID**	170 (08/06/18)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N103 (11/01/15)	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.	**1316**	**CLAIMS FOR DEPARTMENT CORRECTIONS INMATE**	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N104 (10/16/03)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0484**	**ESRD POSSIBLY ELIGIBLE FOR MEDICARE**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0682**	**SERVICE/PRODUCT NOT ELIGIBLE UNDER MEDICAID PROGRAM**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0884**	**CLAIM DENIED/SUBMIT DME CLAIM TO MEDICARE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0945**	**'CARE ASSIGNMENT NOT ACCEPTED - CLAIM NOT PAYABLE BY 'CAID**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0963**	**RECIPIENT HAS MEDICARE - BILL MEDICARE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0970**	**BILL THIRD PARTY CARRIER OR MEDICARE HMO FIRST**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**0979**	**RECIPIENT IS MCARE PART B OR MCARE HMO ELIGIBLE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**1006**	**CLAIM IS 100% MEDICARE-COVERED - NO MEDICAID PAYMENT DUE**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	**1836**	**CLAIM CHECK: CLAIM WAS BYPASSED**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N109 (08/01/15)	Alert: This claim/service was chosen for complex review.	**0958**	**DENIED ACCORDING TO MEDICAID/MEDICAL REVIEW GUIDELINES**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0701**	**DUPLICATE CONSULTATION**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0795**	**CLAIM ADJUSTED BY SYSTEM - NEW ICN**	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0805**	**INPATIENT AND HOME HEALTH DUPLICATE ERROR**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0806**	**LTC AND HOME HEALTH DUPLICATE ERROR**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0827**	**PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0840**	**EXACT DUPLICATE WITHIN GROUP PRACTICE**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N111 (01/01/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0951**	**POSSIBLE DUPLICATE CCF - SEE RA MESSAGE #300**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0954**	**CLAIM REPROCESSED TO CORRECT PAYMENTOR**	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**0956**	**CLAIM REPROCESSED TO CORRECT PAYMENT**	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N111 (01/01/13)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**1878**	**CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0236**	**PROCEDURE/PLACE OF SERVICE RESTRICTION**	58 (01/01/14)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0242**	**SPECIAL PROGRAM/PROGRAM STATUS CODE-PROCEDURE RESTRICTION**	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0244**	**INVALID PROGRAM STATUS FOR SEMI PROCDURES**	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0299**	**SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0427**	**FQHC DELIVERY HCPCS MINUS ENCOUNTER RATE.**	97 (12/27/04)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**0436**	**SUBMITTER NOT ELIGIBLE FOR CLAIM TYPE ON ACTIVITY DATE**	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N115 (08/01/16)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**1007**	**SUD PLACE OF SERVICE RESTRICTION**	58 (08/01/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (01/27/21)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**1468**	**PROC CODE RESTRICT FOR NON-ADDP RECIEP(PSC NOT EQUAL TO 780)**	B5 (01/27/21)	Coverage/program guidelines were not met or were exceeded.
N115 (07/01/23)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**1472**	**SPECIAL PROGRAM CODE RESTRICTION FOR SERVICE DATE(S)**	B5 (07/01/23)	Coverage/program guidelines were not met or were exceeded.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**1831**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE**	7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	**1893**	**CLAIM CHECK: PROCEDURE GENDER RESTRICTION**	7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N122 (12/01/22)	Add-on code cannot be billed by itself.	**1855**	**CLAIMSXTEN ADD ON EDIT**	B15 (12/01/22)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**0254**	**PROCEDURE CODE NDC AGE RESTRICTED**	6 (01/01/14)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**0351**	**RECIP AGE AT THE TIME OF STERILIZATION CONSENT DTE < 21**	6 (11/01/15)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**0358**	**SECOND OPINION - DATE RESTRICTION**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**0359**	**SECOND OPINION DATE AND AGE RESTRICTION**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**0524**	**INVALID LTC PSYCH RECIPIENT AGE**	50 (11/01/15)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/21)	Not eligible due to the patient's age.	**1705**	**DOULA VISIT EXCEEDS AGE LIMIT**	6 (01/01/21)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	**1825**	**CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT**	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	**1826**	**CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT**	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N129 (01/01/14)	Not eligible due to the patient's age.	**1827**	**CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT**	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	**1828**	**CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT**	6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (01/01/14)	Not eligible due to the patient's age.	**1881**	**CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED**	6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0009**	**SERVICES NOT COVERED FOR THIS RECIPIENT.**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0268**	**ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE**	269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0303**	**RECIPIENT IS SERVICE OR PROVIDER RESTRICTED**	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0304**	**PRESUMPTIVELY ELIGIBLE RECIPIENT (NON-COVERED)**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0310**	**GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES**	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0404**	**DURATION STANDARD EXCEEDED - POSSIBLE CUTBACK**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0535**	**DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION PERIOD AUTHORIZED**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0536**	**DAILY QUANTITY POSSIBLY EXCEEDED**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0537**	**DAILY DRUG QUANTITY EXCEEDED; IMMEDIATE PA REQUIRED**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0538**	**DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0615**	**DRG NOT EFFECTIVE ON CLAIM SERVICE DATE**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0667**	**COMPUTED DRUG COST ALLOW IS ZERO - VERIFY/CORRECT QUANTITY**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0715**	**MENTAL HEALTH SERVICES OVER $400-NF/BOARDING HOME**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0716**	**PROCEDURE INCLUDED IN THE PHYSICIAN VISIT**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0730**	**SPECIMEN COLLECTION GREATER THAN ONE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0738**	**REFILL EXCEEDS PROGRAM MAXIMUM**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0753**	**SURGERY/VISIT CONFLICT**	49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0760**	**NORPLANT EXCEED 2 IN 5 YEARS - SAME PROVIDER**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0761**	**NORPLANT EXCEEDS 2 IN 5 YEARS - DIFFERENT PROVIDER**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0764**	**PARTIAL CARE AND FULL DAY NOT PAYABLE ON SAME DAY**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0765**	**DELIVERY/ABORTION PROCEDURE LIMITS**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0766**	**WAIVER SERVICE CONFLICT**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0767**	**PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0834**	**TBI COUNSELING EXCEEDS $600/MNTH**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0835**	**TBI TRANSPORTATION EXCEEDS $100/WK**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0836**	**TBI ENVIRONMENTAL MOD EXCEEDS $5000/MNTH**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0849**	**RENTAL DENIED/PRIOR PURCHASE WITHIN 24 MONTHS**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0851**	**DME RENTAL LIMIT 6 IN 24 MONTHS EXCEEDED**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0852**	**DME RENTAL LIMIT 10 IN 24 MONTHS EXCEEDED**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0853**	**PURCHASE DENIED/6 PRIOR RENTALS WITHIN 24 MONTHS**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0854**	**PURCHASE DENIED/10 PRIOR RENTALS IN 24 MONTHS**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0855**	**PURCHASE DENIED/PRIOR PURCHASE WITHIN 24 MONTHS**	108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0900**	**ZERO PAYMENT - INFORMATIONAL EPSDT CLAIM ONLY**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0938**	**VOIDED CLAIM EXCEEDS PROGRAM LIMITS**	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**0953**	**CLAIM VOIDED - SERVICE BILLED INCORRECTLY**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1367**	**HMS COMMERCIAL TPL RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1368**	**HMS COMMERCIAL TPL RECOVERY-PROVIDER ADJUSTMENTS ALLOWED**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1369**	**HMS CREDIT BALANCE RECOVERY - EXCESS PAY**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1370**	**HMS CREDIT BALANCE RECOVERY - READMISSION**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1371**	**HMS CREDIT BALANCE RECOVERY - TRANSFER**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1372**	**HMS CREDIT BALANCE RECOVERY - DUPLICATE PAYMENT**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1407**	**NOT A COVERED SERVICE UNDER MSP FOR SLMB OR QI**	204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1467**	**NOT A COVERED SERVICE UNDER MSP FOR QMB**	204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1609**	**LONG TERM PSYCHIATRIC CLAIM REDUCED BY PR1**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**1611**	**PARTIAL PR-1 DEDUCTION APPLIED**	151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2032**	**DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2035**	**INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2151**	**RX IS A COMPOUND, NOT BILLED AS A COMPOUND**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2157**	**DOC HAS NO DIRECTIONS (SIG) FOR USE/EXCESSIVE QTY OF DAYS**	204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2323**	**DAILY MORPHINE MILLIGRAM EQUIVALENT > 50**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.	**2324**	**DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	**0024**	**POS REVERSAL REJECTED-RESUBMIT USING FD-999 FORM.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	**0786**	**PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED-RESUBMIT CLAIM**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (01/01/16)	The original claim was denied. Resubmit a new claim, not a replacement claim.	**0955**	**CLAIM VOIDED - RESUBMITTED AS ORIGINAL CLAIM**	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.	**0999**	**PROCESSING ERROR/CLAIM WAS RESUBMITTED BY FISCAL AGENT**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N147 (11/01/15)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	**0326**	**LTC RECIPIENT NOT ON FILE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	**0513**	**LTC CROSSOVER CLAIM REQUIRES A MEDICARE PER DIEM RATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	**0612**	**PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N157 (01/01/14)	Transportation to/from this destination is not covered.	**0739**	**TRANSPORT CLAIM MUST PAY FIRST**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N163 (11/01/15)	Medical record does not support code billed per the code definition.	**0126**	**COMPOUND DRUG INDICATOR INVALID**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	**0106**	**CONSECUTIVE LEAVE TYPES-OVERLAPPING DATES OF SERVICES**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	**0643**	**OUT OF REGION NON-DRG HOSPITAL REQ MAN PRICING FOR DOS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	**0644**	**OUT OF REG NON-DRG HOSP REQ MAN PRICING-NO PROV RATE RECORD**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.	**1669**	**NO RECORD OF AN EPISODE OF CARE ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N174 (05/01/16)	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	**0629**	**PATIENT LIABILITY CONFLICT - PAYMENT REDUCED**	96 (05/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N174 (01/01/14)	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	**1624**	**PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N175 (11/01/15)	Missing review organization approval.	**0264**	**SPECIAL PROGRAM CODE - REVIEW ATTACHMENT**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N175 (11/01/15)	Missing review organization approval.	**0338**	**HYSTERECTOMY PROC REQ REVIEW OF HYST RECEIPT OF INFO FORM**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.	**0042**	**INV/MISS TYPE BILL CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.	**0658**	**NO PROVIDER RATE RECORD FOR BILLING PROVIDER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.	**1439**	**ROUTINE HOME CARE HOSPICE WITH MOD 22 PRICED AT LOWER RATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.	**1444**	**SERVICE INTENSITY ADD-ON PROCEDURE BEYOND 7 DAYS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N193 (11/01/15)	Alert: Specific federal/state/local program may cover this service through another payer.	**1313**	**INVALID CLAIM TYPE FOR DEPT OF CORRECTIONS**	258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
N199 (11/01/15)	Additional payment/recoupment approved based on payer-initiated review/audit.	**0991**	**STATE APPROVED PAYMENT**	B12 (11/01/15)	Services not documented in patient's medical records.
N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.	**0170**	**EXCESSIVE ANESTHESIA UNITS - PEND FOR MEDICAL REVIEW**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.	**0195**	**CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.	**0191**	**REVIEW RA MESSAGE PAGE FOR EXPLANATION**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.	**1604**	**NO FQHC DELIVERY, OB/GYN OR ENCOUNTER MATCHING CLAIM**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N206 (11/01/19)	The supporting documentation does not match the information sent on the claim.	**1685**	**NO FQHC GROUP COUNSELING MATCHING CLAIM**	250 (11/01/19)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N207 (11/01/15)	Missing/incomplete/invalid weight.	**0043**	**INV/MISS BIRTH WEIGHT**	240 (11/01/15)	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N207 (11/01/15)	Missing/incomplete/invalid weight.	**0496**	**INVALID BIRTH WEIGHT / DRG**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N207 (09/09/13)	Missing/incomplete/invalid weight.	**1344**	**BIRTH WEIGHT ON CLAIM AND DRG CONFLICT**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	**0198**	**VERIFY AND/OR CORR DRG CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	**0602**	**MISSING OR INVALID DRG CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	**0609**	**DRG DIRECT COST, LOW TRIM OR HIGH TRIM PER DIEM EQUAL ZERO**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (01/01/14)	Missing/incomplete/invalid DRG code.	**0621**	**DRG CODE NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (05/01/16)	Missing/incomplete/invalid DRG code.	**0657**	**MISSING NJ DRG PAYOR FACTOR**	16 (05/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	**0661**	**INV/MISS DRG CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N213 (11/01/15)	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	**0647**	**MISSING PENNSYLVANIA DRG EXEMPT PER DIEM RATE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**0261**	**OPERATIVE/ANES. , HISTORY AND/OR PATH REPORT REQUESTED.**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**0471**	**FQHC ENCOUNTER WITH NO PD HCPCS ON HIST**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**1610**	**NO MATCH FOUND IN HISTORY FOR HOSPITAL ADJUSTMENT**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N214 (06/26/17)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**1675**	**CCBHC ENCOUNTER WITH NO PD CCBHC ON HIST**	163 (06/26/17)	Attachment/other documentation referenced on the claim was not received.
N214 (07/01/21)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**1709**	**OORP WEEKLY SERVICE(X4) WITH NO PD INIT SVC (X3)**	163 (07/01/21)	Attachment/other documentation referenced on the claim was not received.
N214 (01/01/22)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**1710**	**INCK SCREENING & NO PAID ANNUAL OR E&M VISIT PAID**	163 (01/01/22)	Attachment/other documentation referenced on the claim was not received.
N216 (01/01/14)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	**0270**	**ROUTINE IMMUNIZATION FOR HEPTITIS "A" IS NON-COVERED SERVICE**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N216 (01/01/12)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	**1339**	**RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N221 (11/01/15)	Missing Admitting History and Physical report.	**0874**	**ADJ/VOID AND MATCHING HISTORY CLAIM MUST BOTH BE MEDIA 7**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N221 (11/01/15)	Missing Admitting History and Physical report.	**0889**	**GA MATCHING HISTORY NOT FOUND**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N225 (01/01/16)	Incomplete/invalid documentation/orders/notes/summary/report/chart.	**0318**	**MED NEEDY SPENDDOWN RECIP- ATTACHMENT REVIEW**	251 (01/01/16)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	**0393**	**PAAD/SR GOLD PAYMENT BASED ON PENDING MEDICARE ENROLLMENT**	22 (10/16/03)	This care may be covered by another payer per coordination of benefits.
N245 (09/01/20)	Incomplete/invalid plan information for other insurance.	**0430**	**OTHER COVERAGE CODE VALUE IS INVALID**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	**0460**	**INSURANCE ATTACHMENT INVALID/MISSING**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N245 (11/01/15)	Incomplete/invalid plan information for other insurance.	**0848**	**ADJUST CLM MISSING PAYER/CARRIER CODE AND/OR TPL PAYMENT**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N245 (01/29/16)	Incomplete/invalid plan information for other insurance.	**0975**	**RESOURCE FILE INDICATES INSURANCE OTHER THAN THAT BILLED**	22 (01/29/16)	This care may be covered by another payer per coordination of benefits.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N247 (11/01/15)	Missing/incomplete/invalid assistant surgeon taxonomy.	**0087**	**CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.	**1882**	**CLAIM CHECK: ASSISTANT SURGEON DENIED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.	**1883**	**CLAIM CHECK: ASSISTANT AT SURGERY DENIED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/14)	Missing/incomplete/invalid assistant surgeon secondary identifier.	**0841**	**PROVIDER CANNOT BE SURGEON & ASST SURGEON/ANESTHESIOLOGIST**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	**1296**	**PROVIDER ID AND NPI REQUIRED - OPERATING 2**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	**1393**	**OPERATING 2 PROVIDER INELIGIBLE ON DATES OF SERVICE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.	**1399**	**OPERATING 2 PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N251 (09/01/20)	Missing/incomplete/invalid attending provider taxonomy.	**2147**	**5.1 VERSION NOT ALLOWED FOR SUBMITTER APPROVED FOR D.O**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N252 (01/15/13)	Missing/incomplete/invalid attending provider name.	**1223**	**NPI IS MISSING FOR ATTENDING PROVIDER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N252 (01/15/13)	Missing/incomplete/invalid attending provider name.	**1224**	**NPI IS INVALID FOR ATTENDING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N253 (01/15/13)	Missing/incomplete/invalid attending provider primary identifier.	**0005**	**INV/MISS ATTENDING PHYSICIAN MEDICAID ID NUMBER**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (01/01/14)	Missing/incomplete/invalid attending provider primary identifier.	**0200**	**ATTENDING PHYSICIAN NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (11/01/15)	Missing/incomplete/invalid attending provider primary identifier.	**0949**	**CLAIM VOIDED - BILLING PROVIDER ERROR**	206 (11/01/15)	National Provider Identifier - missing.
N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.	**1269**	**ATTENDING NPI SAME AS BILLING/SERVICING NPI**	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (09/07/10)	Missing/incomplete/invalid attending provider primary identifier.	**1295**	**UB04 OPERATING 2 NPI. SAME AS BILLING/SERVICE NPI.**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.	**1406**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - ATTENDING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.	**1419**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - ATTENDING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.	**1243**	**NPI NOT CROSSWALKED - ATTENDING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.	**1244**	**PROVIDER NOT MATCHED - ATTENDING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	**1260**	**PROVIDER ID AND NPI REQUIRED - ATTENDING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	**1389**	**ATTENDING PROVIDER INELIGIBLE ON DATES OF SERVICE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	**1395**	**ATTENDING PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.	**1403**	**NPI NOT CROSSWALKED-ATTENDING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.	**0796**	**BILLING PROVIDER NOT MATCHED ON HISTORY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (01/01/14)	Missing/incomplete/invalid billing provider taxonomy.	**0839**	**ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.	**1217**	**TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.	**1218**	**TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.	**1298**	**TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.	**1299**	**TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.	**1332**	**UNSUBMITTED TAXONOMY CODE WAS DEFAULTED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**0002**	**BILLING PROVIDER NUMBER MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**0007**	**BILLING PROVIDER CHECK DIGIT INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (02/01/19)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**0204**	**SERVICING AND BILLING PROVIDERS NOT LINKED ON D.O.S.**	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**0206**	**BILLING PROVIDER NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**0230**	**BILLING OR SERVING PROVIDER NOT VALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**1229**	**NPI IS MISSING FOR BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**1230**	**NPI IS INVALID FOR BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**1404**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - BILLING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**1415**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - BILLING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	**1240**	**NPI NOT CROSSWALKED - BILLING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	**1241**	**PROVIDER NOT MATCHED - BILLING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N259 (01/01/13)	Missing/incomplete/invalid billing provider/supplier secondary identifier.	**1242**	**PROVIDER ID AND NPI REQUIRED - BILLING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.	**0212**	**SERV PROV NOF/ LTC COTTAGE NUMBER INVALID**	207 (11/01/15)	National Provider identifier - Invalid format
N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.	**0216**	**SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED**	208 (11/01/15)	National Provider Identifier - Not matched.
N262 (09/07/10)	Missing/incomplete/invalid operating provider primary identifier.	**1280**	**NPI INVALID - UB04 OPERATING 2 PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (01/15/13)	Missing/incomplete/invalid operating provider primary identifier.	**1281**	**UB04 OPERATING 1 NPI SAME AS BILLING/SERVICING NPI.**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	**1411**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 1**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	**1412**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 2**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	**1421**	**NPI NOT MAPPED WITH NEW JERSEY PROVIDER ID - OPERATING 1**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.	**1422**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 2**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	**1227**	**NPI IS MISSING FOR OPERATING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	**1228**	**NPI INVALID - UB04 OPERATING 1 PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.	**1261**	**NPI NOT CROSSWALKED - OPERATING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.	**1262**	**PROVIDER NOT MATCHED - UB04 OPERATING 1 PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/01/13)	Missing/incomplete/invalid operating provider secondary identifier.	**1266**	**PROVIDER ID AND NPI REQUIRED - OPERATING 1**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (09/07/10)	Missing/incomplete/invalid operating provider secondary identifier.	**1282**	**NPI NOT CROSSWALKED-UB04 OPERATING 2 PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	**1392**	**OPERATING 1 PROVIDER INELIGIBLE ON DATES OF SERVICE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.	**1398**	**OPERATING 1 PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N265 (01/01/14)	Missing/incomplete/invalid ordering provider primary identifier.	**0224**	**PRESCRIBING PHYSICIAN/PRACTIONER NUMBER NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N265 (01/15/13)	Missing/incomplete/invalid ordering provider primary identifier.	**1234**	**NPI INVALID FOR PRESCRIBING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.	**1390**	**PRESCRIBING PROVIDER INELIGIBLE ON DATES OF SERVICE**	184 (01/15/13)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.	**1396**	**PRESCRIBING PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N269 (01/01/14)	Missing/incomplete/invalid other provider name.	**0218**	**REFERRING/OTHER PHYSICIAN PROVIDER NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (01/01/14)	Missing/incomplete/invalid other provider primary identifier.	**0006**	**INVALID REFERRING/OTHER PROVIDER IDENTIFIER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	**1231**	**NPI IS MISSING FOR OTHER PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	**1232**	**NPI IS INVALID FOR OTHER PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.	**1271**	**OTHER NPI SAME AS BILLING/SERVICING NPI**	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.	**1264**	**NPI NOT CROSSWALKED - OTHER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.	**1265**	**PROVIDER NOT MATCHED - OTHER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N276 (11/01/15)	Missing/incomplete/invalid other payer referring provider identifier.	**0639**	**REFERRING PROVIDER MUST BE NURSING FACILITY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N279 (11/01/15)	Missing/incomplete/invalid pay-to provider name.	**1628**	**REQUIRED DENTAL CLAIM NOT RECEIVED FOR SAME DOS**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N285 (11/01/15)	Missing/incomplete/invalid referring provider name.	**0275**	**RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	**0231**	**REFERRING PROVIDER NUMBER REQUIRED - GSHP**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	**0262**	**REFER/OTHER PHY REQ FOR CONSULT AND/OR 2ND OPINION**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.	**0277**	**REFERRING PROVIDER NUMBER REQUIRED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	**0331**	**SECOND OPINION REQUIRED**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	**0333**	**INVALID/MISSING SECOND OPINION INDICATOR**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.	**0339**	**DENY SECOND OPINION NOT OBTAINED**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.	**1226**	**NPI IS INVALID FOR REFERRING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (07/01/08)	Missing/incomplete/invalid referring provider primary identifier.	**1270**	**REFERRING NPI SAME AS BILLING/SERVICING NPI**	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.	**1410**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - REFERRING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.	**1420**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - REFERRING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.	**1246**	**NPI NOT CROSSWALKED - UB04 REFERRING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.	**1247**	**PROVIDER NOT MATCHED - REFERRING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.	**1263**	**PROVIDER ID AND NPI REQUIRED - REFERRING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.	**1397**	**REFERRING PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	**1219**	**TAXONOMY CODE IS MISSING FOR SERVICING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	**1220**	**TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	**1221**	**NPI IS MISSING FOR SERVICE/RENDERING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	**1222**	**NPI IS INVALID FOR SERVICE/RENDERING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/09/11)	Missing/incomplete/invalid rendering provider primary identifier.	**1306**	**NPI IS INVALID FOR SUPERVISING PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.	**1405**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SERVICING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.	**1418**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SERVICING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	**1236**	**ZIP CODE IS MISSING OR INVALID**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	**1237**	**NPI NOT CROSSWALKED - SERV/REND**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	**1238**	**PROVIDER NOT MATCHED - SERV/REND**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (01/01/13)	Missing/incomplete/invalid rendering provider secondary identifier.	**1245**	**PROVIDER ID AND NPI REQUIRED - SERVICING**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.	**1297**	**BILLING ZIP CODE IS MISSING OR INVALID**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.	**1307**	**NPI NOT CROSSWALKED - SUPERVISING PROVIDER**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (07/14/14)	Missing/incomplete/invalid rendering provider secondary identifier.	**1427**	**NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SUPERVISING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N297 (11/01/15)	Missing/incomplete/invalid supervising provider primary identifier.	**1305**	**INVALID SUPERVISING MEDICAID PROVIDER ID.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N297 (07/14/14)	Missing/incomplete/invalid supervising provider primary identifier.	**1414**	**NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SUPERVISING**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.	**1394**	**SUPERVISING PROVIDER INELIGIBLE ON DATES OF SERVICE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.	**1402**	**SUPERVISING PROVIDER NOT FOUND ON PROVIDER DATABASE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).	**0014**	**STATEMENT THRU DATE < OCCURRENCE DATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).	**0189**	**EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (01/01/14)	Missing/incomplete/invalid occurrence span date(s).	**0069**	**INVALID OCCURENCE DATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	**0364**	**CLAIM SPANS HMO ENROLLMENT - CALL REVS**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	**1285**	**INVALID UB04 OCCURRENCE SPAN FROM DATE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).	**1287**	**STATEMENT THRU DATE < UB04 OCCUR SPAN THRU DATE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N301 (11/01/15)	Missing/incomplete/invalid procedure date(s).	**0135**	**INV/MISS CURRENT EXAM DATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N302 (11/01/15)	Missing/incomplete/invalid other procedure date(s).	**1650**	**MISSING QUALIFYING OTHER PROCEDURE ON DAY OF SERVICE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N304 (11/01/15)	Missing/incomplete/invalid dispensed date.	**0137**	**CURRENT EXAM GREATER THAN DATE DISPENSED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N306 (11/01/15)	Missing/incomplete/invalid acute manifestation date.	**0499**	**ACUTE DAYS BILLED EQUAL ZERO**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.	**0183**	**MEDICARE PAYMENT DATE IS MISSING OR INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.	**1379**	**PMT AMT ON THE APPROVED HMS ADJ GT THAN OR EQUAL TO ORIG PMT**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N318 (01/01/14)	Missing/incomplete/invalid discharge or end of care date.	**0018**	**SERVICE THRU DATE < SERVICE FROM DATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**0013**	**INVALID BIRTHDATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N329 (11/01/15)	Missing/incomplete/invalid patient birth date.	**0311**	**CORRECT D.O.B. OR RESUBMIT CLAIM UNDER BABY'S NUMBER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**1809**	**CLAIM CHECK: DOB CANNOT BE GREATER THAN DATE OF SERVICE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**1821**	**CLAIM CHECK: BIRTH DATE IS A FUTURE DATE**	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (12/12/07)	Missing/incomplete/invalid patient birth date.	**1824**	**CLAIM CHECK: AGE CANNOT BE GREATER THAN 124 YEARS**	6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**1849**	**CLAIM CHECK: INVALID DATE OF BIRTH CENTURY VALUE**	16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**1850**	**CLAIM CHECK: INVALID DATE OF BIRTH**	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	**0383**	**DATE OF SERVICE LATER THAN DATE OF DEATH**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	**0384**	**DATE OF SERVICE LATER THAN DATE OF DEATH**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (01/01/16)	Missing/incomplete/invalid patient death date.	**1440**	**PROCEDURE NEEDS A DATE OF DEATH TO BE PROCESSED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	**1643**	**CLAIM VOID PENDED - UNCONFIRMED RECIPIENT DEATH**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N330 (11/01/15)	Missing/incomplete/invalid patient death date.	**1644**	**CLAIM VOIDED - RECIPIENT DEATH**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N341 (01/01/14)	Missing/incomplete/invalid surgery date.	**0049**	**INV/MISS SURG DATE - SUPPLY VALID DATE OR REMOVE PROC CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N345 (06/18/07)	Date range not valid with units submitted.	**1819**	**CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N345 (06/18/07)	Date range not valid with units submitted.	**1823**	**CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS**	16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	**0324**	**HMO COVERED SERVICE - PAYMENT NOT JUSTIFIED BY ATTACHMENT**	B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	**0876**	**CO-PAY FOR SERVICE DATE PAID - SEE CONFLICTING ICN ON RA**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N350 (11/01/15)	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	**0669**	**DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N351 (01/01/14)	Service date outside of the approved treatment plan service dates.	**0782**	**GSHP DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE**	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
N354 (11/01/15)	Incomplete/invalid invoice.	**0640**	**INVOICE/PRICE LIST ATTACHED IS INVALID/INSUFFICIENT**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N357 (03/01/20)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	**1682**	**TELEDENTISTRY CODE REQUIRES RELATED SERVICE CODE**	B15 (03/01/20)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N357 (01/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	**1686**	**SUD MGMT CLAIM WITH NO MATCHING E&M CLAIM**	B15 (01/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N357 (12/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	**1687**	**GROUP CLINICAL VISIT CLAIM WITH NO MATCHING E&M CLAIM**	B15 (12/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	**1703**	**POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D**	272 (01/01/21)	Coverage/program guidelines were not met.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0148**	**RESPITE CARE EXCEEDS MAXIMUM OF 5 DAYS**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0276**	**UTILIZATION EXCEEDS ESTABLISHED PARAMETERS**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	**0403**	**DURATION AT THIS DOSAGE EXCEEDED**	119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.

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N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0672**	**SPLIT CLAIM RECIP ELIG ON DISCHARGE DATE ONLY-NO PMT DUE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0673**	**SPLIT CLAIM ALL ELIG DAYS ARE RESIDENTIAL-NO PAYMENT DUE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0674**	**SPLIT CLAIM SNF/ICF DAYS AT/BELOW DRG HIGH TRIM-NO PMT DUE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0675**	**SPLIT CLAIM NJ HIV OUTLIER CLAIM-SNF/ICF DAYS NOT PAYABLE**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	**0699**	**LIFETIME RESERVE DAYS EXCEED MEDICARE MAXIMUM OF 60 DAYS**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0705**	**CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0706**	**30 DAY NEONATAL CARE LIMIT**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0707**	**60 DAY NEONATAL CARE LIMITATION**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0712**	**CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM-DENY**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	**0720**	**TARGETED CASE MANAGEMENT LIMIT EXCEEDED**	119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**0733**	**CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**0837**	**TBI BEHAVIOR PROGRAM EXCEEDS UNITS OF SERVICE**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**0859**	**CLAIM OVERLAPS CALENDAR WORK WEEK-SUN.12:00AM TO SAT.11:59PM**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**0910**	**PAYMENT EXCEEDS THRESHOLD**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**0936**	**INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**1012**	**VALUE OF ONE OR MORE OF THESE FIELDS WAS > MAX ALLOWED**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/29/16)	The number of Days or Units of Service exceeds our acceptable maximum.	**1606**	**RATE DECREASE WHEN PARTIAL HOSPITALIZATION EXCEEDS 24 MONTH**	119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**1623**	**OUTPATIENT ACUTE ADULT PARTIAL HOSPITALIZATION TIME EXCEEDED**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (06/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**1649**	**OP TRANS PMT REDUCED BY PREVIOUS PAID OP TRANS CLM**	119 (06/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (01/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.	**1651**	**MAX UNITS REACHED FOR 2 CONSECUTIVE DAY OCCURRENCE**	222 (01/01/15)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.	**1652**	**MENTAL HEALTH CLAIM CUTBACK - BENEFIT LIMIT REACHED**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.	**1670**	**NUMBER OF UNITS EXCEEDS 6 IN A 14 DAY PERIOD**	96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N362 (01/01/16)	The number of Days or Units of Service exceeds our acceptable maximum.	**1805**	**CLAIM CHECK: CLAIM LINES EXCEED MAXIMUM**	119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.
N375 (11/01/15)	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	**0386**	**KID-CARE UNABLE TO DETERMINE COVERAGE**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.	**0128**	**CLAIM > $400-RESUB CLAIM VERIFYING METRIC QUANTITY REPORTED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.	**1330**	**METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N378 (05/02/11)	Missing/incomplete/invalid prescription quantity.	**1349**	**VERIFY METRIC QUANTITY REPORTED**	226 (05/02/11)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0203**	**PROVIDER ON REVIEW - STATE PEND**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0207**	**BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0222**	**LTC AGREEMENT TERMINATED:DISCHARGE PENDING FINAL DAY**	27 (11/01/15)	Expenses incurred after coverage terminated.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0243**	**PROVIDER NOT AUTHORIZED-TARGETED CASE MANAGEMENT**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0281**	**POS VOID TRANSACTION FOR PROVIDER-ON-REVIEW**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0282**	**POS PROVIDER ON REVIEW-NO Z NO OVERRIDE**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0691**	**PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVIC**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0736**	**LAB SERVICE**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0762**	**MENTAL HEALTH SERVICES EXCEED $900**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N381 (01/29/16)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**0990**	**DELAYED PAYMENT OF PROPRIETARY ELECTRONIC CLAIM**	119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**1207**	**PAYMENT PENDING SFY JULY 1 APPROPRIATION**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**1210**	**PART A EXHAUSTED CHARGES IS GREATER THAN 99,999,99**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**1363**	**CANNOT CHANGE A DOCUMENT LEVEL SURGERY**	A1 (02/13/12)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	**1364**	**CANNOT ADJUST A LINE LEVEL SURGERY**	A1 (11/15/11)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N382 (02/01/19)	Missing/incomplete/invalid patient identifier.	**0011**	**RECIPIENT NUMBER MISSING OR INVALID**	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (11/01/15)	Missing/incomplete/invalid patient identifier.	**0100**	**ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (01/01/16)	Missing/incomplete/invalid patient identifier.	**0306**	**MEDICAID RECIP ID CORRECTED**	16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (11/01/15)	Missing/incomplete/invalid patient identifier.	**0321**	**RECIPIENT NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N383 (01/01/14)	Not covered when deemed cosmetic.	**1804**	**CLAIM CHECK: COSMETIC PROCEDURE**	50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N383 (01/01/14)	Not covered when deemed cosmetic.	**1807**	**CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED**	50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N388 (11/01/15)	Missing/incomplete/invalid prescription number.	**0131**	**INV/MISS PRESCRIPTION NUMBER**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N388 (09/01/20)	Missing/incomplete/invalid prescription number.	**2169**	**RX IS NOT ON FILE OR INCOMPLETE**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N391 (11/01/15)	Missing emergency department records.	**0878**	**NO EMERGENCY CLAIM FOR ALIEN TRANSPORTATION CLAIM**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N398 (11/01/15)	Missing elective consent form.	**0354**	**HYSTERECTOMY REQUIRES ATTACHMENT**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	**0033**	**SUBMITTER ID IS NOT NUMERIC OR = "O".**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	**0227**	**PROVIDER NOT APPROVED FOR EMC**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N407 (11/01/15)	You are not an approved submitter for this transmission format.	**0271**	**SUBMITTER NOT APPROVED FOR PROVIDER.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N407 (11/01/15)	You are not an approved submitter for this transmission format.	**0437**	**INVALID SUBMITTED ID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N408 (11/01/15)	This payer does not cover deductibles assessed by a previous payer.	**0455**	**RECIPIENT NOT ELIGIBLE ON FROM D.O.S. NO DEDUCTIBLE DUE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N408 (02/01/16)	This payer does not cover deductibles assessed by a previous payer.	**1388**	**MEDICARE HMO DEDUCTIBLE EXCEEDS YEARLY MAXIMUM**	96 (02/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N418 (11/01/15)	Misrouted claim. See the payer's claim submission instructions.	**0400**	**NOT VALID CAPITATION CLAIM**	109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N424 (08/01/24)	Patient does not reside in the geographic area required for this type of payment.	**1663**	**CLAIM VOIDED - PARIS MATCH**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N429 (01/01/14)	Not covered when considered routine.	**0752**	**VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM**	49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N430 (11/01/15)	Procedure code is inconsistent with the units billed.	**0149**	**CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (01/29/16)	Alert: Adjustment based on a Recovery Audit.	**0964**	**ADJUSTMENT OR VOID CORRESPONDS TO CANCELLED MMIS CHECK**	97 (01/29/16)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	**1348**	**HMS AUDIT - ADJUSTMENT/VOID REQUEST DENIED**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	**1373**	**HMS MEDICARE RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	**1374**	**HMS MEDICARE RECOVERY - PROVIDER ADJUSTMENTS ALLOWED**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	**1376**	**HMS RAC RECOVERY - NO FURTHER PROVIDER ADJUSTMENTS**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.	**1377**	**HMS RAC RECOVERY PROVIDER ADJUSTMENTS ALLOWED**	97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N434 (12/09/13)	Missing/Incomplete/Invalid Present on Admission indicator.	**1312**	**MISSING OR INVALID PRESENT ON ADMISSION INDICATOR.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N434 (11/01/15)	Missing/Incomplete/Invalid Present on Admission indicator.	**1320**	**POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE.**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	**0731**	**THREE YEAR XRAY LIMITATION EXCEEDED**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	**0857**	**WEEKLY PERSONAL CARE ASSISTANCE/MENTAL HEALTH HRS EXCEED 25**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.	**0858**	**WEEKLY PERSONAL CARE ASSISTANT (PCA) SVCS HOURS EXCEED 40**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N435 (01/01/21)	Exceeds number/frequency approved /allowed within time period without support documentation.	**1702**	**DOULA VISITS EXCEED LIMIT**	119 (01/01/21)	Benefit maximum for this time period or occurrence has been reached.
N440 (11/01/15)	Incomplete/invalid anesthesia physical status report/indicators.	**0160**	**INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N443 (01/01/14)	Missing/incomplete/invalid total time or begin/end time.	**0314**	**CLAIM SERV. DATES OVERLAP SPEC. PROG. ELIG. BEGIN/END DATES.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N445 (11/01/15)	Missing document for actual cost or paid amount.	**0239**	**ALTERED DOCUMENTATION-ORIGINAL PRICE LIST/INVOICE NEEDED**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N446 (11/01/15)	Incomplete/invalid document for actual cost or paid amount.	**0105**	**FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	**0573**	**CAPITATION RATE NOT ON FILE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	**1216**	**DRUG REBATE INDICATOR ZERO OR NO MCAID/GA REBATE AGREEMENT**	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N463 (11/01/15)	Missing support data for claim.	**0366**	**MISSING/INVALID STERILIZATION TIME REASON**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	**0648**	**INVALID NEW YORK EXEMPT UNIT RATE CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	**0649**	**MISSING NEW YORK EXEMPT UNIT RATE DATA**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	**0659**	**NF RATE NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.	**0671**	**MEDICARE RATE NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**0199**	**SUBMIT HARD COPY CLAIM AND MEDICARE EOB**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**0511**	**OVERRIDE-USE PROVIDER MEDICARE PER DIEM RATE.**	22 (11/01/15)	This care may be covered by another payer per coordination of benefits.
N479 (01/01/16)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**0845**	**ADJUSTMENT DENIED/ EOMB REQUIRED**	P21 (01/01/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**1621**	**DENY REASON CODE OR DENY EXPLANATION MISSING ON EOB**	P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
N480 (01/29/16)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**0984**	**CLAIM REQUIRES REVIEW - MEDICARE PART B ATTACHMENT**	16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N480 (11/01/15)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**0988**	**NEGATIVE MEDICARE EOB, REBILL AS ZERO PRIOR PAY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N517 (01/01/14)	Resubmit a new claim with the requested information.	**0293**	**DIAGNOSIS NOT ALLOWED FOR SEX**	10 (01/01/14)	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N517 (01/01/14)	Resubmit a new claim with the requested information.	**0411**	**GSHP PRIOR AUTHORIZATION NOT REQUIRED..**	15 (01/01/14)	The authorization number is missing, invalid, or does not apply to the billed services or provider.
N517 (01/01/14)	Resubmit a new claim with the requested information.	**0479**	**PRIV PSYCH HOSP - LTC-PAT AGE > 21 AND < 65**	9 (01/01/14)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N517 (01/01/16)	Resubmit a new claim with the requested information.	**0597**	**VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE**	181 (01/01/16)	Procedure code was invalid on the date of service.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**0162**	**INV/MISS PROCEDURE CODE MODIFIER**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**0256**	**PROCEDURE MODIFIER REQUIRED**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**0267**	**PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**0519**	**MODIFIER ADDED - TRIP OVER 15 MILES**	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**0860**	**PROCEDURE CODE MODIFIERS IN CONFLICT**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**1834**	**CLAIM CHECK: INVALID MODIFIER**	4 (06/18/07)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0695**	**ADJUSTMENT / VOID ALREADY IN PROCESS**	18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0800**	**EXACT DUPLICATE BILL**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0801**	**POSSIBLE DUPLICATE CONFLICT**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0802**	**PHYSICIAN AND EPSDT DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0803**	**INPATIENT AND LTC DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0804**	**INPATIENT AND OUTPATIENT DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0807**	**INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0809**	**POSSIBLE DUPLICATE**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0810**	**DUPLICATE BILL - OVERLAPPING DATES OF SERVICES**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0812**	**TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0813**	**OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0814**	**PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0815**	**AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0816**	**CLINIC AND CLINIC CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0817**	**P&O AND P&O CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0818**	**DME AND DME CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0819**	**LAB AND LAB CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0820**	**OPTOMETRIST AND OPTOMETRIST CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0821**	**MID-LEVEL PRACT AND CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0822**	**EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0823**	**LTC AND LTC CROSSOVER DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**0865**	**LTC AND HOSPICE DUPLICATE ERROR**	18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1201**	**MULTIPLE HIST RECS FOUND FOR ADJ/VOID**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1607**	**FQHC DUPLICATE CONFLICT**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1622**	**CHARITY AND MEDICAID DUPLICATE ERROR**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1631**	**THERAPY CONFLICT WITH RESIDENTIAL, PARTIAL CARE, TRANSPORT**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1641**	**HOSPICE TRANSFER WITH MORE THAN ONE OVERLAPPING SERVICE DAY**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1642**	**HOSPICE XFER DAY OF DISCHARGE WITH > 1 OVERLAPPING SVC DAY**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (05/04/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1673**	**DEPT. OF CORRECTIONS/MEDICAID DUPLICATE ERROR**	18 (05/04/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1812**	**CLAIM CHECK: PROCEDURE CODE IS MISSING**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**1813**	**CLAIM CHECK: DATE OF SERVICE REQUIRED FOR PROCEDURE**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N531 (01/01/14)	Not qualified for recovery based on direct payment of premium.	**0773**	**DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE(S)**	198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.
N538 (11/01/15)	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	**0645**	**MISSING NEW YORK EXEMPT FACILITY RATE DATE**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N554 (11/01/15)	Missing/Incomplete/Invalid Family Planning Indicator.	**0147**	**FAMILY PLANNING INDICATOR MUST BE Y OR N**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N567 (05/01/16)	Not covered when considered preventative.	**1340**	**PROVIDER PREVENTABLE CONDITION - NOT COVERED**	233 (01/01/14)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
N569 (12/01/22)	Not covered when performed for the reported diagnosis.	**1860**	**CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE**	A1 (12/01/22)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	**0201**	**SERVICING PROVIDER NOT ELIGIBLE ON DATE(S) OF SERVICE**	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	**0210**	**PROVIDER NOT CERTIFIED FOR THIS PROCEDURE**	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	**0387**	**BILLING PROVIDER NOT ENROLLED IN CLIA**	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (01/01/14)	Missing/incomplete/invalid credentialing data.	**0388**	**BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE**	B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N570 (11/01/15)	Missing/incomplete/invalid credentialing data.	**0389**	**BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE**	B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N570 (11/01/15)	Missing/incomplete/invalid credentialing data.	**0650**	**MISSING PENNSYLVANNIA HOSPITAL FISCAL YEAR DATA**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N572 (01/01/14)	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	**1204**	**ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ**	4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	**1325**	**INVALID PROVIDER TYPE FOR REFERRING PROVIDER**	183 (04/02/10)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	**1336**	**INVALID REFERRING PROVIDER FOR PLACE OF SERVICE 2 OR 4**	183 (01/23/12)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	**1382**	**INVALID PROVIDER TYPE - PRESCRIBING PHYSICIAN**	184 (11/01/15)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	**0026**	**CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING LIMITS**	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	**0027**	**INPATIENT CLAIM W/O ATTACHMENT EXCEEDS TIMELY FILING LIMITS**	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	**0029**	**MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT**	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	**0076**	**CLAIM W/ATTACH EXCEEDS TIMELY FILING**	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.	**0077**	**I/P CLAIM EXCEEDS TIMELY FILING LIMIT**	164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.
N587 (11/01/15)	Policy benefits have been exhausted.	**0717**	**PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N587 (01/01/14)	Policy benefits have been exhausted.	**0875**	**FISCAL YEAR FUNDS EXHAUSTED**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N587 (04/01/18)	Policy benefits have been exhausted.	**1014**	**DDD SELF DIRECTED INSUFFICIENT PA FUNDING TO FULFILL CLAIM**	119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.
N587 (04/02/18)	Policy benefits have been exhausted.	**1015**	**DDD/IME CLAIM MODIFIERS DO NOT MATCH PA MODIFIERS**	119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	**1255**	**MEDICARE SUP CLAIM W/O EXHAUSTED DATE OR CHARGES**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	**1256**	**MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	**1257**	**MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N587 (11/01/15)	Policy benefits have been exhausted.	**1627**	**EXHAUSTED CHARGES A3 AMOUNT REPORTED ON THE CLAIM**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N622 (01/01/14)	Not covered based on the date of injury/accident.	**0021**	**BILLED DATE LESS THAN THRU DATE**	110 (01/01/14)	Billing date predates service date.
N622 (01/01/14)	Not covered based on the date of injury/accident.	**0023**	**BILLED DATE < STATEMENT THRU DATE**	110 (01/01/14)	Billing date predates service date.
N622 (11/01/15)	Not covered based on the date of injury/accident.	**0424**	**ELIG ENDED BEFORE CLAIM THRU DATE FOR DME-CUTBACK APPLIED**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N622 (01/01/14)	Not covered based on the date of injury/accident.	**0490**	**INPATIENT DATE OF SURGERY < SERVICE FROM DATE**	110 (01/01/14)	Billing date predates service date.
N622 (01/01/14)	Not covered based on the date of injury/accident.	**0529**	**CLAIM DATES OF SERVICE BEFORE INITIAL ASSESSMENT DATE**	110 (01/01/14)	Billing date predates service date.
N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	**0722**	**SERVICE/VISIT CONFLICT**	231 (11/01/15)	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	**1655**	**SERVICE/VISIT CONFLICT**	234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N629 (11/28/16)	Reviews/documentation/notes/summaries/reports/charts not requested.	**1448**	**SERVICE NOT RELATED TO TERMINAL COND FOR HOSPICE BENEFICIARY**	95 (11/28/16)	Plan procedures not followed.
N630 (11/01/15)	Referral not authorized by attending physician.	**1391**	**REFERRING PROVIDER INELIGIBLE ON DATES OF SERVICE**	183 (01/15/13)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N633 (01/01/14)	Additional anesthesia time units are not allowed.	**0759**	**PAYMENT REDUCED - SURGERY/ANESTHESIA CONFLICT**	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N637 (01/01/14)	Consultations are not allowed once treatment has been rendered by the same provider.	**0745**	**HOSPITAL CALL/CONSULTATION CONFLICT**	97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0734**	**SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0740**	**OPT APP EXCEEDS PROGRAM LIMITATION**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0747**	**PROPHYLAXIS LIMIT**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0748**	**ORAL EXAMINATION LIMIT**	119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0768**	**EXCESSIVE PRIVATE DUTY NURSING HOURS-PA REQUIRED**	222 (01/01/14)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.	**0872**	**FAMILYCARE THERAPY SERVICE LIMITS**	119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.
N640 (11/01/15)	Exceeds number/frequency approved/allowed within time period.	**1008**	**CARRIER AMOUNT EXCEEDS MAXIMUM VALUE ALLOWED**	B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.
N640 (01/01/16)	Exceeds number/frequency approved/allowed within time period.	**1858**	**CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM**	119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.
N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).	**0881**	**URO/DRG AUDIT ADJUST - REQUEST DENIED**	167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N647 (01/01/14)	Adjusted based on diagnosis-related group (DRG).	**0924**	**DISCHARGE DATE AND READMIT DATE WITHIN SET TIME SPANS FOR NY**	167 (01/01/14)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).	**1401**	**PAYMENT ADJUSTED FOR HOSPITAL ACQUIRED CONDITION**	233 (12/09/13)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
N652 (11/01/15)	The date of service is before the date of loss.	**0110**	**DATE OF SERVICE < ADMISSION DATE**	26 (11/01/15)	Expenses incurred prior to coverage.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0058**	**INV/MISS PROCEDURE CODE/REVENUE CODE/CHARGE**	199 (11/01/15)	Revenue code and Procedure code do not match.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0066**	**INVALID SPECIAL PROGRAM INDICATOR**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0081**	**INV/MISS CLINIC CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0082**	**EMERG ROOM REV CODE (S) PRESENT - CLINIC CODE '00' MISSING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0083**	**REV CODE 099,36X,37X,49X OR 71X REQ VALID SURGICAL PROC**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0138**	**ACCIDENT INDICATOR MUST BE Y, N, OR SPACE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0139**	**EPSDT INDICATOR NOT Y, N OR SPACE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0142**	**INV/MISS ORIGIN CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0143**	**INV/MISS DESTINATION CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0235**	**INVALID DIVISION OF JUVENILE SERVICES CLAIM.**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0241**	**22 MOD SERVICES NOT JUSTIFIED/PAID AT UNMODIFIED RATE**	4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0251**	**PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0253**	**REVENUE/PROCEDURE NOT VALID ON DATE(S) OF SERVICE**	181 (11/01/15)	Procedure code was invalid on the date of service.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0480**	**GROUPER ASSIGNED A NEW DRG CODE**	A8 (11/01/15)	Ungroupable DRG.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0665**	**PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST**	199 (11/01/15)	Revenue code and Procedure code do not match.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**0725**	**BIOPSY D&C CONFLICT**	236 (11/01/15)	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**1303**	**MENTAL HEALTH SERVICE UNDER 2 NOT COVERED**	9 (05/21/12)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**1328**	**BILL OUTPATIENT DRUG CLAIMS USING REVENUE CODES 631 THRU 637**	199 (03/29/10)	Revenue code and Procedure code do not match.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**1378**	**FQHC MENTAL HEALTH/MEDICAL PROC/DIAG MISMATCH**	11 (11/01/15)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (01/01/16)	This should be billed with the appropriate code for these services.	**1441**	**RECIP OUTSIDE 60 DAYS NOT ELIGIBLE FOR HIGHER HOSPICE RATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**1660**	**NO APPROPRIATE E&M, MH OR SUD CODE IN HISTORY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N657 (09/01/20)	This should be billed with the appropriate code for these services.	**2170**	**ACQUISITION INVOICE DOES NOT SUPPORT NDC BILLED**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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N657 (09/01/20)	This should be billed with the appropriate code for these services.	**2183**	**EXCEEDED REFILLS ALLOWED**	16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N661 (08/02/20)	Documentation does not support that the services rendered were medically necessary.	**1426**	**EARLY ELECTIVE DELIVERY**	50 (08/01/20)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.	**1469**	**EARLY ELECTIVE DELIVERY DENIAL OVERRIDDEN**	50 (01/01/21)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N663 (01/01/15)	Adjusted based on an agreed amount.	**1347**	**MLTSS WAIVER FFS CLAIM REPROCESS.**	166 (01/01/15)	These services were submitted after this payers responsibility for processing claims under this plan ended.
N666 (01/01/14)	Only one evaluation and management code at this service level is covered during the course of care.	**0735**	**INITIAL VISIT/ANNUAL EXAM/EPSDT EXAM LIMIT**	96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N667 (11/01/15)	Missing prescription.	**0641**	**RX FROM PHYSICIAN REQUIRED**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N668 (09/01/20)	Incomplete/invalid prescription.	**2153**	**RX INCORRECTLY SUBMITTED AS A COMPOUND**	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	**2154**	**INITIAL CONTROLLED DRUG FILLED > 30 DAYS PAST DATE WRITTEN**	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	**2156**	**RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCRBR NPI**	175 (09/01/20)	Prescription is incomplete.

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N668 (09/01/20)	Incomplete/invalid prescription.	**2159**	**RX INCOMPLETE-MISSING/INCOMP/AMBIG PRESRBRS AUTH AGENT**	16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N668 (09/01/20)	Incomplete/invalid prescription.	**2162**	**RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCR INFO**	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	**2166**	**INCORRECT COMPOUND INGREDIENT NDC# SUBMITTED**	175 (09/01/20)	Prescription is incomplete.
N668 (09/01/20)	Incomplete/invalid prescription.	**2175**	**NO NAME ON RX**	175 (09/01/20)	Prescription is incomplete.
N669 (05/01/16)	Adjusted based on the Medicare fee schedule.	**0623**	**MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE**	23 (01/01/14)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	**0901**	**MULTIPLE SURGERY-PAID AS PRIMARY PROCEDURE**	59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	**0902**	**MULTIPLE SURGERY-PAID AS SECONDARY PROC, MAX 200% OF PRIMARY**	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	**0903**	**MULT SURG - PRIME PROC FEE REDUCED BY PRIOR PAID CLAIM**	59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N670 (11/01/15)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	**0904**	**MULTIPLE SURGERY-$0 PAID, LIMIT EXCEEDED**	59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	**0907**	**MULT SURG- 1ST UNIT PRIMARY, ADDT'L AS SECONDARY - 200% MAX**	59 (10/16/03)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.	**1463**	**PENDING DOULA INCENTIVE PAYMENT FOR REPROCESS**	B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.	**1704**	**DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS**	B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	**1322**	**SERVICE/PROCEDURE INCLUDED IN COMPOSITE RATE**	234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	**1337**	**ASC PROCEDURE SERVICE**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	**0452**	**CERTIFICATION OF EMERGENCY FORM MISSING/INVALID**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	**0453**	**PA/CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM**	163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.
N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.	**0909**	**REQUIRES MATCHING EPSDT CLAIM FOR PAYMENT**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N702 (01/29/16)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	**0825**	**INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM**	18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

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N702 (11/01/15)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	**0899**	**DUPLICATE ICN**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N702 (12/04/17)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	**1676**	**DAILY/WEEKLY PSYCHOTHERAPY SERVICE LIMITS EXCEEDED**	18 (12/04/17)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N702 (07/01/20)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	**1688**	**CLM FOR REQUIRED BASE TIME CODE NOT RECEIVED FOR ADD ON CODE**	129 (07/01/20)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N702 (01/01/21)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	**1752**	**NO PRESUMPTIVE DRUG TEST WITHIN 7 DAYS**	129 (01/01/21)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N705 (05/01/16)	Incomplete/invalid documentation.	**0838**	**PROVIDER-PRODUCED EOB INCOMPLETE**	251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N705 (12/07/20)	Incomplete/invalid documentation.	**1459**	**PRA INVALID- NO RECIPIENT FOUND FOR PRENATAL SERVICE**	226 (12/07/20)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N705 (08/17/21)	Incomplete/invalid documentation.	**1464**	**PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE**	226 (08/17/21)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
N705 (08/17/21)	Incomplete/invalid documentation.	**1465**	**PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS**	226 (08/17/21)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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NJMMIS Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 4/20/2025

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N706 (11/01/15)	Missing documentation.	**0349**	**SEC OPINION FORM INCOMPLETE,MISSING DATA OR IS OUT OF DATE**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N706 (11/01/15)	Missing documentation.	**0352**	**INSUFFICIENT MEDICAL DOCUMENTATION FOR STERILIZATION**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N706 (11/01/15)	Missing documentation.	**0355**	**STERILIZATION FORM REQUIRED**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N706 (11/01/15)	Missing documentation.	**0464**	**HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED**	252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N706 (01/01/16)	Missing documentation.	**0842**	**ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED**	163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.
N822 (12/01/22)	Missing procedure modifier(s).	**1856**	**CLAIMSXTEN: MISSING MODIFIER 26**	4 (12/01/22)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N883 (01/15/24)	Alert: Processed according to state law	**1473**	**TPL EDITING BYPASSED - PAY AND CHASE CLAIM**	22 (01/15/24)	This care may be covered by another payer per coordination of benefits.
N950 (07/12/21)		**0546**	**PAAD/SR GOLD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER**	184 (01/01/14)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.