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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**162**	**PROCEDURE CODE MODIFIER MISSING/INVALID**	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (02/16/15)	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.	**961**	**CLAIM CHECK: INVALID MODIFIER**	N519 (02/16/15)	Invalid combination of HCPCS modifiers.
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.	**968**	**CLAIMSXTEN: MISSING MODIFIER 26**	N822 (12/01/22)	Missing procedure modifier(s).
5 (10/16/03)	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.	**141**	**PLACE OF SERVICE MISSING/INVALID**	M77 (10/16/03)	Missing/incomplete/invalid/inappropriate place of service.
6 (10/16/03)	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.	**254**	**PROCEDURE CODE AND AGE RESTRICTED**	N129 (11/01/15)	Not eligible due to the patient's age.
6 (01/01/21)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**805**	**DOULA VISIT EXCEEDS AGE LIMIT**	N129 (01/01/21)	Not eligible due to the patient's age.
6 (02/16/15)	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.	**929**	**CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT**	N129 (02/16/15)	Not eligible due to the patient's age.
6 (02/16/15)	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.	**930**	**CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT**	N129 (02/16/15)	Not eligible due to the patient's age.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
6 (02/16/15)	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.	**931**	**CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT**	N129 (02/16/15)	Not eligible due to the patient's age.
6 (02/16/15)	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.	**932**	**CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT**	N129 (02/16/15)	Not eligible due to the patient's age.
6 (02/16/15)	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.	**941**	**CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED**	N129 (02/16/15)	Not eligible due to the patient's age.
7 (10/16/03)	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.	**255**	**PROCEDURE CODE AND SEX RESTRICTION.**	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
7 (02/16/15)	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.	**933**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE**	N517 (02/16/15)	Resubmit a new claim with the requested information.
7 (02/16/15)	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.	**934**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE**	N517 (02/16/15)	Resubmit a new claim with the requested information.
7 (02/16/15)	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.	**953**	**CLAIM CHECK: PROCEDURE GENDER RESTRICTION**	N517 (02/16/15)	Resubmit a new claim with the requested information.
8 (06/28/11)	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.	**003**	**PROCEDURE CODE/CAPITATION PROVIDER TYPE UNMATCHED**	N77 (10/16/03)	Missing/incomplete/invalid designated provider number.

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10 (11/01/15)	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.	**312**	**MEDIA 7 CONFLICT RECIPIENT MHC PAYMENT CODE MISSING/INVAL**	N657 (11/01/15)	This should be billed with the appropriate code for these services.
11 (01/01/21)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**425**	**INVALID DIAGNOSIS FOR SERVICE**	N569 (01/01/21)	Not covered when performed for the reported diagnosis.
11 (01/01/21)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**802**	**DOULA VISITS EXCEED LIMIT**	N569 (01/01/21)	Not covered when performed for the reported diagnosis.
13 (01/01/16)	The date of death precedes the date of service.	**701**	**DATE OF SERVICE LATER THAN DATE OF DEATH**		
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.	**001**	**INCORRECT CLAIM STATUS CODE**	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.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**010**	**SERVICING PROVIDER MISSING/INVALID**	MA102 (01/01/14)	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.
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.	**011**	**RECIPIENT NUMBER MISSING OR INVALID**	N282 (02/01/19)	Missing/incomplete/invalid pay-to provider secondary identifier.

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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**013**	**INVALID BIRTHDATE**	N329 (01/01/14)	Missing/incomplete/invalid patient birth 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.	**015**	**STATEMENT THRU DATE < STATEMENT FROM DATE**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**016**	**SERVICE FROM DATE MISSING/INVALID**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**017**	**SERVICE THRU DATE MISSING/INVALID**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**018**	**SERVICE THRU DATE < SERVICE FROM DATE**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**020**	**SERVICE THRU DATE > DATE RECEIVED**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**022**	**CAPITATION SERVICE PERIOD INVALID**	M52 (08/04/09)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**025**	**DISPENSE DATE INVALID**	N57 (10/16/03)	Missing/incomplete/invalid prescribing date.

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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**042**	**TYPE OF BILL CODE MISSING/INVALID**	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
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.	**044**	**ADMISSION TYPE MISSING/INVALID**	MA41 (10/16/03)	Missing/incomplete/invalid admission type.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**045**	**PATIENT STATUS CODE MISSING/INVALID**	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**046**	**INVALID/MISSING OCCURRENCE SPAN CODE**	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**047**	**INVALID/OCCURRENCE SPAN FROM OR THRU DATE**	M46 (09/24/12)	Missing/incomplete/invalid occurrence span code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**049**	**SURGICAL DATE MISSING/INVALID**	N341 (11/01/15)	Missing/incomplete/invalid surgery date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**056**	**REVENUE UNITS MISSING/INVALID**	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**058**	**REVENUE/CHARGE/CODE INVALID**	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**068**	**ADMISSION SOURCE MISSING/INVALID**	MA42 (10/16/03)	Missing/incomplete/invalid admission source.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**071**	**STATEMENT COVERS FROM DATE MISSING/INVALID**	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**072**	**STATEMENT COVERS THRU DATE MISSING/INV**	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**073**	**SERVICE COVERS FROM DATE < STATEMENT FROM DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**074**	**STATEMENT COVERS FROM DATE > SERVICE THRU DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**085**	**DAYS/UNITS/VISITS MISSING/INVALID**	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**086**	**ASSISTED LIVING SERVICE UNITS NOT EQUAL TO SERVICE DAYS**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**087**	**SURGICAL PROVIDER NPI MISSING**	N261 (11/01/15)	Missing/incomplete/invalid operating provider name.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**089**	**DATE OF SURGERY > SERVICE/STATEMENT THRU DATE**	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**100**	**NO REVENUE CODE FOUND EXCEPT 001**	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).
016 (11/01/19)		**101**	**ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK**	N382 (11/01/15)	Missing/incomplete/invalid patient identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**110**	**ENC TAXONOMY MISSING/INVALID**	N288 (11/01/15)	Missing/incomplete/invalid rendering provider taxonomy.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**124**	**PATIENT ACCOUNT NUMBER MISSING/INVALID**	MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.

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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**126**	**COMPOUND DRUG INDICATOR MISSING/INVALID**	M123 (11/01/15)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
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.	**127**	**NATIONAL DRUG CODE MISSING OR INVALID**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**131**	**PRESCRIPTION NUMBER MISSING/INVALID**	N57 (10/16/03)	Missing/incomplete/invalid prescribing date.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**133**	**EMPLOYMENT RELATED INDICTOR MISSING/INVALID**	MA90 (11/01/15)	Missing/incomplete/invalid employment status code for the primary insured.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**135**	**CURRENT EXAM DATE MISSING/INVALID**	N324 (01/01/14)	Missing/incomplete/invalid last seen/visit 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.	**136**	**PREVIOUS EXAM DATE INV**	N342 (11/01/15)	Missing/incomplete/invalid test performed 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.	**151**	**CLAIM CHARGE MISSING/INVALID**	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**152**	**TOTAL CHARGE MISSING/INVALID**	M54 (10/16/03)	Missing/incomplete/invalid total charges.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**153**	**CLAIM PAYMENT MISSING/INVALID**	M54 (10/16/03)	Missing/incomplete/invalid total charges.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**161**	**PROCEDURE CODE MISSING/INVALID**	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**172**	**PAYOR ID MISSING/INVALID**	M56 (10/16/03)	Missing/incomplete/invalid payer identifier.
16 (11/06/06)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**183**	**HMO PAYMENT DATE MISSING/INVALID**	N307 (11/06/06)	Missing/incomplete/invalid adjudication or payment date.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**185**	**FORMER ICN # MISSING/INVALID**	M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**197**	**COMPOUND DRUG OR METRIC QUANTITY ERROR**	N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.
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.	**206**	**BILLING PROVIDER NUMBER NOT ON FILE**	N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**214**	**INVALID NDC OR NDC NOT ON FILE**	M119 (10/27/14)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**215**	**PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE**	M20 (10/27/14)	Missing/incomplete/invalid HCPCS.
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.	**217**	**TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER**	N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**218**	**TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER**	N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**219**	**TAXONOMY CODE IS MISSING FOR SERVICE PROVIDER**	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**220**	**TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER**	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**221**	**NPI IS MISSING FOR SERVICE/RENDERING PROVIDER**	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**222**	**NPI IS INVALID FOR SERVICE/RENDERING PROVIDER**	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**223**	**NPI MISSING FOR THE ATTENDING PROVIDER**	N253 (05/23/07)	Missing/incomplete/invalid attending provider primary identifier.

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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.	**224**	**NPI IS INVALID FOR THE ATTENDING PROVIDER**	N253 (05/23/07)	Missing/incomplete/invalid attending provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**225**	**NPI IS MISSING FOR THE REFERRING PROVIDER**	N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**226**	**NPI IS INVALID FOR THE REFERRING PROVIDER**	N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**227**	**NPI IS MISSING FOR THE OPERATING PROVIDER**	N262 (05/23/07)	Missing/incomplete/invalid operating provider primary identifier.

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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.	**228**	**NPI IS INVALID FOR THE OPERATING PROVIDER**	N262 (05/23/07)	Missing/incomplete/invalid operating provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**229**	**NPI IS MISSING FOR BILLING PROVIDER**	N265 (05/23/07)	Missing/incomplete/invalid ordering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**230**	**NPI IS INVALID FOR BILLING PROVIDER**	N265 (05/23/07)	Missing/incomplete/invalid ordering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**231**	**NPI IS MISSING FOR OTHER PROVIDER**	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.

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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.	**232**	**NPI IS INVALID FOR OTHER PROVIDER**	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**233**	**NPI IS MISSING FOR PRESCRIBING PROVIDER**	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**236**	**ZIP CODE MISSING OR INVALID**	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**248**	**SURGICAL PROCEDURE CODE NOT ON FILE**	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**253**	**PROCEDURE NOT VALID ON DATE(S) OF SERVICE**	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**259**	**PROCEDURE CODE NOT ON FILE**	M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).
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.	**269**	**ATTENDING NPI SAME AS BILLING/SERVICING NPI**	N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.
16 (09/28/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**270**	**REFERRING NPI SAME AS BILLING/SERVICING NPI**	286 (09/28/15)	

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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.	**271**	**OTHER NPI SAME AS BILLING/SERVICING NPI**	N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.
16 (09/28/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**281**	**OPERATING 1 NPI SAME AS BILLING/SERVICING NPI**	N262 (09/28/15)	Missing/incomplete/invalid operating provider primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**289**	**ADMITTING DIAGNOSIS CODE NOT ON FILE**	MA65 (09/01/20)	Missing/incomplete/invalid admitting diagnosis.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**296**	**DIAGNOSIS CODE NOT ON FILE**	MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.

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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**297**	**BILLING ZIP CODE MISSING OR INVALID**	N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**298**	**TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER**	N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**299**	**TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER**	N284 (11/01/15)	Missing/incomplete/invalid referring provider taxonomy.
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.	**300**	**MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY**	M123 (10/27/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.

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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**317**	**INVALID/MISSING METRIC QUANTITY**	M123 (10/27/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**319**	**MISSING OR INVALID PRESENT ON ADMISSION INDICATOR**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**320**	**POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**322**	**CLAIM UOM INVALID OR NOT = NDC UOM - SEE WWW.NJMMIS.COM**	M49 (10/27/14)	Missing/incomplete/invalid value code(s) or amount(s).

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**328**	**BILL OP DRUG CLAIMS USING REVENUE CODES 631 -637, 891 OR 25X**	M50 (10/27/14)	Missing/incomplete/invalid revenue code(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**330**	**METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED**	M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (01/01/12)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**339**	**RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS**	N216 (01/01/12)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**349**	**VERIFY METRIC QUANTITY REPORTED**	N378 (10/27/14)	Missing/incomplete/invalid prescription quantity.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (10/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**416**	**ICD VERSION MISMATCH**	M64 (10/01/14)	Missing/incomplete/invalid other diagnosis.
16 (10/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**428**	**UNSPECIFIED DIAGNOSIS CODE**	M81 (10/01/14)	You are required to code to the highest level of specificity.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**451**	**UNKNOWN FIELD POPULATED WITH INVALID DATA**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**464**	**PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (12/13/10)	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.	**466**	**COMPOUND CLAIM WITH ONLY 1 INGREDIENT**	M44 (10/16/03)	Missing/incomplete/invalid condition code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**479**	**GROUPER COULD NOT ASSIGN A DRG CODE**	N208 (11/01/15)	Missing/incomplete/invalid DRG code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**503**	**REVENUE CODE NOT ON FILE**	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**551**	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**	M44 (10/27/14)	Missing/incomplete/invalid condition code.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**553**	**COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (12/13/10)	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.	**554**	**COMPOUND CONTAINS DUPLICATE INGREDIENTS**	M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**597**	**VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE**	M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**601**	**NO ADJUSTMENT ALLOWED FOR MEDIA 7 ELIGIBLE CLAIMS**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**660**	**SERVICE UNITS NOT EQUAL TO ACCOMMODATION DAYS**	M53 (03/13/17)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**726**	**SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY**	N31 (01/01/19)	Missing/incomplete/invalid prescribing 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.	**727**	**CLAIM VOIDED/ADJ FOR REBATE UNIT (OIG AUDIT 2019)**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**755**	**SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**757**	**AMDC SERVICE EXCEEDS PROGRAM FREQUENCY GUIDLINES**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**785**	**ENCOUNTER INCLUDED IN PAST FINANCIAL SETTLEMENT**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**786**	**PREVIOUSLY DENIED CLM CANNOT BE ADJUSTED-RESUBMIT CLAIM**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**787**	**ADJUSTMENT CLM TYPE NOT MATCHED**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (04/21/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**789**	**INCENTIVE PAYMENT SUPPRESSED AGAINST RECONCILED CLAIM**	MA130 (04/21/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/16)	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.	**796**	**SUBMITTER NOT MATCHED ON HISTORY**	N255 (01/01/16)	Missing/incomplete/invalid billing provider taxonomy.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**806**	**INPATIENT AND OUTPATIENT DUPLICATE ERROR**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**808**	**AMDC/INPATIENT CLAIM DATE CONFLICT**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**924**	**CLAIM CHECK: PROCEDURE CODE IS OBSOLETE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**927**	**CLAIM CHECK: INVALID PROCEDURE CODE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**939**	**CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**944**	**CLAIM CHECK: NEW PATIENT PROC NOT APPROPRIATE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**945**	**CLAIM CHECK: CCI INCIDENTAL PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**946**	**CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**947**	**CLAIM CHECK: INCIDENTAL PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**949**	**CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**956**	**CLAIM CHECK: MEDICAL VISIT PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**957**	**CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**959**	**CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS**	N345 (02/16/15)	Date range not valid with units submitted.
16 (02/16/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**960**	**CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS**	N345 (02/16/15)	Date range not valid with units submitted.
18 (11/02/09)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**024**	**DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER/NDC**	N389 (11/02/09)	Duplicate prescription number submitted.

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18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**797**	**DUPLICATE ADJUSTMENT**	N522 (01/01/16)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**798**	**HISTORY RECORD ALREADY ADJUSTED OR VOIDED**	N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**800**	**EXACT DUPLICATE BILL**	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (08/25/25)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**807**	**INPATIENT TO INPATIENT POSSIBLE DUPLICATE ERROR**	N522 (08/29/25)	Duplicate of a claim processed, or to be processed, as a crossover claim.
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**702**	**TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT**		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**706**	**INSURANCE COVERAGE KNOWN, OTHER COVERAGE CODE = 0**		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	**707**	**MEDICAID PAYMENT REDUCED BY OTHER INSURANCE**		
23 (07/01/12)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**911**	**MANAGED CARE SUB-VENDOR REPORTING CAPITATED PAYMENT**	N219 (07/01/12)	Payment based on previous payer's allowed amount.
26 (11/01/15)	Expenses incurred prior to coverage.	**301**	**RECIPIENT INELIGIBLE ON DATES OF SERVICE**	N30 (10/16/03)	Patient ineligible for this service.
26 (01/02/25)	Expenses incurred prior to coverage.	**326**	**RECIPIENT NOT ELIGIBLE FOR MFP SERVICES AND GOODS**	N30 (01/02/25)	Patient ineligible for this service.
28 (07/03/23)	Coverage not in effect at the time the service was provided.	**028**	**PPP SERVICE SUBMITTED AS OVERTIME DENIED.**	N30 (07/03/23)	Patient ineligible for this service.
29 (10/01/11)	The time limit for filing has expired.	**019**	**SERVICE PERIOD IS MORE THAN 3 YEARS OLD**	M59 (10/01/11)	Missing/incomplete/invalid 'to' date(s) of service.
29 (09/01/20)	The time limit for filing has expired.	**026**	**CLAIM EXCEEDS TIMELY FILING LIMITS**		
31 (11/01/15)	Patient cannot be identified as our insured.	**321**	**RECIPIENT NUMBER NOT ON FILE**	MA61 (11/01/15)	Missing/incomplete/invalid social security number.

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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.	**311**	**HMO SENT 'M' TO REQUEST MEDIA 7 REIMBURSEMENT CLAIM NOT ELG**	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.
50 (10/21/25)	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.	**313**	**MCO SENT "M" TO REQUEST MEDIA 7 PAYMENT CAP CODE INELIGIBLE**	M49 (10/21/25)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**426**	**EARLY ELECTIVE DELIVERY**	N661 (08/01/20)	Documentation does not support that the services rendered were medically necessary.
50 (01/01/21)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**427**	**EARLY ELECTIVE DELIVERY DENIAL OVERRIDE**	N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.
50 (02/16/15)	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.	**920**	**CLAIM CHECK: COSMETIC PROCEDURE**	N383 (02/16/15)	Not covered when deemed cosmetic.
50 (02/16/15)	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.	**922**	**CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED**	N383 (02/16/15)	Not covered when deemed cosmetic.
54 (02/16/15)	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**942**	**CLAIM CHECK: ASSISTANT SURGEON DENIED**	N247 (02/16/15)	Missing/incomplete/invalid assistant surgeon taxonomy.

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
54 (02/16/15)	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**943**	**CLAIM CHECK: ASSISTANT AT SURGERY DENIED**	N247 (02/16/15)	Missing/incomplete/invalid assistant surgeon taxonomy.
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.	**923**	**CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL**	M49 (02/16/15)	Missing/incomplete/invalid value code(s) or amount(s).
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.	**142**	**ORIGIN CODE MISSING/INVALID**	N157 (11/01/15)	Transportation to/from this destination is not covered.
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.	**143**	**DESTINATION CODE MISSING/INVALID**	N157 (11/01/15)	Transportation to/from this destination is not covered.
96 (01/02/14)	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.	**263**	**NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE**	N103 (01/02/14)	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.
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.	**385**	**LOGISTICARE TRANSPORTATION SERVICE NOT COVERED FOR RECIPIENT**	N30 (10/16/03)	Patient ineligible for this service.

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97 (02/16/15)	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.	**926**	**CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE**	M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.
97 (02/16/15)	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.	**940**	**CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)**	M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.
97 (02/16/15)	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.	**950**	**CLAIM CHECK: POST OPERATIVE PROCEDURE CODE**	M144 (02/16/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
97 (02/16/15)	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.	**951**	**CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE**	M144 (02/16/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
97 (02/16/15)	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.	**952**	**CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**	M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).
97 (02/16/15)	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.	**955**	**CLAIM CHECK: DUPLICATE PROCEDURE**	M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**138**	**ACCIDENT INDICTOR MISSING/INVALID**	N576 (11/01/15)	Services not related to the specific incident/claim/accident/loss being reported.
109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**400**	**RECIPIENT NOT IN HMO ON DATE OF SERVICE**	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.

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109 (01/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**710**	**PART D COVERAGE KNOWN BILL FOR PART D PLAN**		
110 (05/04/09)	Billing date predates service date.	**023**	**VOID MATCHED MULTIPLE ENCOUNTERS**	MA31 (05/04/09)	Missing/incomplete/invalid beginning and ending dates of the period billed.
110 (11/01/15)	Billing date predates service date.	**064**	**SERVICE THRU DATE > STATEMENT THRU DATE**	N622 (11/01/15)	Not covered based on the date of injury/accident.
114 (11/01/15)	Procedure/product not approved by the Food and Drug Administration.	**555**	**COMPOUND DRUG - INCORRECT INGREDIENT QUANTITY/COST**	N623 (11/01/15)	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
114 (11/01/15)	Procedure/product not approved by the Food and Drug Administration.	**556**	**INVALID COMPOUND - CONTAINS ONE INGREDIENT + WATER**	N623 (11/01/15)	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
114 (01/01/16)	Procedure/product not approved by the Food and Drug Administration.	**704**	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**		
119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.	**724**	**CLAIM SUBMITTED AS A 340B CLAIM**	N45 (04/01/17)	Payment based on authorized amount.
119 (01/01/18)	Benefit maximum for this time period or occurrence has been reached.	**725**	**CLAIM VOIDED/ADJUSTED DUE TO INCORRECT HMO PAYMENT AMOUNT**	N45 (01/01/18)	Payment based on authorized amount.
120 (10/01/20)	Patient is covered by a managed care plan.	**014**	**PPP SERVICE SUBMITTED AS OVERTIME**	N649 (10/01/20)	Payment based on invoice.
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.)	**021**	**INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD**	M59 (04/01/12)	Missing/incomplete/invalid 'to' date(s) of service.
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.)	**027**	**NO MATCHING CLAIM FOR ENC VOID/ADJ ON PHARMACY VSAM FILE**	N101 (06/01/12)	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
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).	**603**	**MOTHER VS. BABY CLAIM. NEWBORN INDICATORS DO NOT MATCH**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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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).	**709**	**MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
146 (02/16/15)	Diagnosis was invalid for the date(s) of service reported.	**963**	**CLAIM CHECK: INVALID DIAGNOSIS CODE**	M76 (02/16/15)	Missing/incomplete/invalid diagnosis or condition.
146 (02/16/15)	Diagnosis was invalid for the date(s) of service reported.	**965**	**CLAIM CHECK: INVALID CLAIM DIAGNOSIS CODE**	M76 (02/16/15)	Missing/incomplete/invalid diagnosis or condition.
153 (01/01/16)	Payer deems the information submitted does not support this dosage.	**713**	**INCORRECT UNIT OF MEASURE REPORTED FOR DRUG**		
163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.	**826**	**TIMELY FILLING DETERMINED BY PREVIOUS CLAIM**	N3 (01/01/16)	Missing consent form.
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.	**166**	**DIAGNOSIS CODE MISSING/INVALID**	MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.
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.	**167**	**DIAGNOSIS CODE MISSING**	MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.
175 (05/10/22)	Prescription is incomplete.	**705**	**PAYMENT DENIED; VACCINE AVAILABLE FROM THE VFC PROGRAM**	N95 (12/22/14)	This provider type/provider specialty may not bill this service.
175 (09/20/20)	Prescription is incomplete.	**728**	**415-DF NUMBER OF REFILLS AUTHORIZED IS NOT NUMERIC**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**729**	**DATE RX WRITTEN > 30 DAYS SCHED II-V**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**730**	**DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**731**	**460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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175 (09/20/20)	Prescription is incomplete.	**732**	**QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**733**	**QTY DISPENSED > QTY PRESCRIBED**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**734**	**NUM OF REFILLS AUTH > O SCHED II**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**735**	**403-D3 FILL NUMBER M/I**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**738**	**343-HD DISPENSING STATUS INVALID**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**740**	**ACCUM O MED EXCEEDS 30 DAYS SUPPLY**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/20)	Prescription is incomplete.	**741**	**M/I INCENTIVE AMOUNT SUBMITTED FIELD (438-E3)**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/20)	Prescription is incomplete.	**742**	**M/I PROFESSIONAL SERVICE CODE (445-E5)**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/20)	Prescription is incomplete.	**743**	**M/I SUBMISSION CLARIFICATIONE CODE (420-DK)**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/20)	Prescription is incomplete.	**744**	**COVID VACCINE ADMINISTRATION CONFLICT**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/20)	Prescription is incomplete.	**745**	**VACCINE ADMINISTRATION EXCEEDED FOR MEMBER**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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175 (12/01/20)	Prescription is incomplete.	**746**	**MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (04/26/21)	Prescription is incomplete.	**747**	**EXCEEDS PROG MAX-GREATER THAN SIX FILLS 6 IN A MONTH PERIOD**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	**748**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II - V**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (06/06/22)	Prescription is incomplete.	**749**	**DAILY MORPHINE MILLIGRAM EQUIVALENT > 50**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (06/06/22)	Prescription is incomplete.	**750**	**DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (02/28/22)	Prescription is incomplete.	**753**	**OTC COVID TEST LIMIT EXCEEDED- LIMIT 4 KITS PER MONTH**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (12/01/23)	Prescription is incomplete.	**754**	**BYPASS OF MED EXCEEDS 30 DAYS SUPPLY**	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
181 (01/01/16)	Procedure code was invalid on the date of service.	**715**	**BENEFIT STAGE AMOUNT IS NOT NUMERIC**		
181 (01/01/16)	Procedure code was invalid on the date of service.	**716**	**PARTD PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED**		
181 (01/01/16)	Procedure code was invalid on the date of service.	**717**	**BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS**		
181 (01/01/16)	Procedure code was invalid on the date of service.	**718**	**INVALID BENEFIT STAGE AMOUNT, NO PARTD PAYER SUBMITTED**		
184 (01/01/16)	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.	**721**	**PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT**		

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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.	**448**	**SUBMITTER NOT ELIGIBLE FOR CLM TYPE OR DOS < 20110701**	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	**130**	**PHARMACY DAYS SUPPLY MISSING/INVALID**	N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
204 (02/20/26)	This service/equipment/drug is not covered under the patient's current benefit plan	**327**	**DISCONTINUED PROC CODES MFP MEDIA 7 PAYMENT**	N301 (02/20/26)	Missing/incomplete/invalid procedure date(s).
204 (07/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	**703**	**DRUG NOT PAYABLE - NO REBATE AGREEMENT**		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**712**	**RECIPIENT ELIGIBLE FOR MEDICARE PART D**		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**714**	**PART D COPAY NOT COVERED AS OF FY2011**		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	**871**	**MEDIA 7 SERVICE LIMIT ERROR**	N666 (01/01/16)	Only one evaluation and management code at this service level is covered during the course of care.
206 (11/01/15)	National Provider Identifier - missing.	**272**	**PRESCRIBING NPI SAME AS BILLING/SERVICING NPI**	N31 (07/01/08)	Missing/incomplete/invalid prescribing provider identifier.
207 (11/01/15)	National Provider identifier - Invalid format	**234**	**NPI IS INVALID FOR PRESCRIBING PROVIDER**	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.
208 (11/01/15)	National Provider Identifier - Not matched.	**006**	**REFERRING/OPERATING/OTHER PROVIDER EIN/SSN INVALID**	N286 (11/01/15)	Missing/incomplete/invalid referring provider primary identifier.
208 (08/16/10)	National Provider Identifier - Not matched.	**329**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	N77 (08/16/10)	Missing/incomplete/invalid designated provider number.
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.)	**459**	**PRA INVALID - NO RECIPIENT FOUND FOR PRENATAL SERVICE**	N705 (12/07/20)	Incomplete/invalid documentation.
226 (08/16/21)	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.)	**465**	**PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS**	N705 (08/16/21)	Incomplete/invalid documentation.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Adj Reason Code

Last Date Loaded - 11/7/2026

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**310**	**HMO SENT 'M' TO REQUEST MEDIA 7 KICK PAYMENT AND MMIS PAID**	N644 (11/01/15)	Reimbursement has been made according to the bilateral procedure rule.
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.	**043**	**INVALID/MISSING BIRTH WEIGHT**	N207 (11/01/15)	Missing/incomplete/invalid weight.
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).	**048**	**SURGICAL PROCEDURE CODE MISSING/INVALID**	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
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).	**083**	**SURGICAL PROCEDURE CODE MISSING**	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
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).	**123**	**MEDICAL RECORD NUMBER MISSING/INVALID**	M127 (11/01/15)	Missing patient medical record for this service.
250 (01/01/16)	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).	**799**	**NO CLAIM IN HISTORY FILE MATCHES ADJUSTMENT**	N214 (01/01/16)	Missing/incomplete/invalid history of the related initial surgical procedure(s).

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	**139**	**EPSDT INDICTOR INVALID**	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.
272 (01/01/21)	Coverage/program guidelines were not met.	**803**	**POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D**	N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
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.	**969**	**CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE**	N569 (12/01/22)	Not covered when performed for the reported diagnosis.
A8 (11/01/15)	Ungroupable DRG.	**480**	**GROUPER ASSIGNED A NEW DRG CODE**	N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).
B1 (11/01/15)	Non-covered visits.	**144**	**PATIENT ACCOUNT NUMBER IDENTIFIES HMO-DENIED CLAIM**	N30 (11/01/15)	Patient ineligible for this service.
B1 (01/01/16)	Non-covered visits.	**700**	**FFS PAYMENT FOR ENCOUNTER NOT ALLOWED-SEE OTHER EDITS ON ENC**		
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.	**711**	**PHARMACY BILLED FOR PART D DEDUCTIBLE AND CO-PAY/COINSURANCE**		
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.	**719**	**BNFT STG 70-NOT PARTD CLM-PD BY NEGOTIATED PRICE-PARTD DRUG**		
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.	**722**	**BNFT STG 61-NOT PARTD CLM-PD BY COADMIN PLAN BNFT-PARTD DRUG**		
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.	**723**	**BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED**		
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**788**	**VOID REQUEST DENIED AGAINST RECONCILED CLAIM**	MA67 (10/16/03)	Alert: Correction to a prior claim.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
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.	**804**	**DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS**	N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.
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.	**958**	**CLAIMSXTEN ADD ON EDIT**	N122 (12/01/22)	Add-on code cannot be billed by itself.
P7 (11/01/15)	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	**544**	**DRUG NOT PAYABLE FEDERAL DESI**	M199 (10/27/14)	
P7 (11/01/15)	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	**545**	**NATIONAL DRUG CODE NOT ON FILE**	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
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.	**184**	**ADJUSTMENT REASON CODE MISSING/INVALID**	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.