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Encounter Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 9/7/2026

HIPAA Remark Code (Mapping Last Change Date) HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
	026	**CLAIM EXCEEDS TIMELY FILING LIMITS**	29 (09/01/20)	The time limit for filing has expired.
	700	**FFS PAYMENT FOR ENCOUNTER NOT ALLOWED-SEE OTHER EDITS ON ENC**	B1 (01/01/16)	Non-covered visits.
	701	**DATE OF SERVICE LATER THAN DATE OF DEATH**	13 (01/01/16)	The date of death precedes the date of service.
	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.
	703	**DRUG NOT PAYABLE - NO REBATE AGREEMENT**	204 (07/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan
	704	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**	114 (01/01/16)	Procedure/product not approved by the Food and Drug Administration.
	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**	22 (01/01/16)	This care may be covered by another payer per coordination of benefits.
	710	**PART D COVERAGE KNOWN BILL FOR PART D PLAN**	109 (01/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
	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.
	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
	713	**INCORRECT UNIT OF MEASURE REPORTED FOR DRUG**	153 (01/01/16)	Payer deems the information submitted does not support this dosage.
	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
	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.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
		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**	181 (01/01/16)	Procedure code was invalid on the date of service.
		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.
		721	**PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT**	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.
		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**	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.
286 (09/28/15)		**270**	**REFERRING NPI SAME AS BILLING/SERVICING NPI**	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.
M20 (10/27/14)	Missing/incomplete/invalid HCPCS.	**215**	**PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
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.	**311**	**HMO SENT 'M' TO REQUEST MEDIA 7 REIMBURSEMENT CLAIM NOT ELG**	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.
M44 (10/16/03)	Missing/incomplete/invalid condition code.	**466**	**COMPOUND CLAIM WITH ONLY 1 INGREDIENT**	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.
M44 (10/27/14)	Missing/incomplete/invalid condition code.	**551**	**NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M46 (09/24/12)	Missing/incomplete/invalid occurrence span code(s).	**047**	**INVALID/OCCURRENCE SPAN FROM OR THRU DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	**185**	**FORMER ICN # MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (10/21/25)	Missing/incomplete/invalid value code(s) or amount(s).	**313**	**MCO SENT "M" TO REQUEST MEDIA 7 PAYMENT CAP CODE INELIGIBLE**	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.
M49 (10/27/14)	Missing/incomplete/invalid value code(s) or amount(s).	**322**	**CLAIM UOM INVALID OR NOT = NDC UOM - SEE WWW.NJMMIS.COM**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M49 (02/16/15)	Missing/incomplete/invalid value code(s) or amount(s).	**923**	**CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL**	55 (04/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).	**058**	**REVENUE/CHARGE/CODE INVALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).	**100**	**NO REVENUE CODE FOUND EXCEPT 001**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M50 (10/27/14)	Missing/incomplete/invalid revenue code(s).	**328**	**BILL OP DRUG CLAIMS USING REVENUE CODES 631 -637, 891 OR 25X**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).	**503**	**REVENUE CODE NOT ON FILE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).	**259**	**PROCEDURE CODE NOT ON FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**924**	**CLAIM CHECK: PROCEDURE CODE IS OBSOLETE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**927**	**CLAIM CHECK: INVALID PROCEDURE CODE**	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.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**939**	**CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**944**	**CLAIM CHECK: NEW PATIENT PROC NOT APPROPRIATE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**945**	**CLAIM CHECK: CCI INCIDENTAL PROCEDURE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**946**	**CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**947**	**CLAIM CHECK: INCIDENTAL PROCEDURE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**949**	**CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**952**	**CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**956**	**CLAIM CHECK: MEDICAL VISIT PROCEDURE**	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.
M51 (02/16/15)	Missing/incomplete/invalid procedure code(s).	**957**	**CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE**	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.
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	**015**	**STATEMENT THRU DATE < STATEMENT FROM DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	**016**	**SERVICE FROM DATE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	**018**	**SERVICE THRU DATE < SERVICE FROM DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (08/04/09)	Missing/incomplete/invalid 'from' date(s) of service.	**022**	**CAPITATION SERVICE PERIOD INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.	**071**	**STATEMENT COVERS FROM DATE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	**046**	**INVALID/MISSING OCCURRENCE SPAN 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.
M53 (11/01/15)	Missing/incomplete/invalid days or units of service.	**056**	**REVENUE UNITS MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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M53 (10/16/03)	Missing/incomplete/invalid days or units of service.	**085**	**DAYS/UNITS/VISITS MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M53 (03/13/17)	Missing/incomplete/invalid days or units of service.	**660**	**SERVICE UNITS NOT EQUAL TO ACCOMMODATION DAYS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (10/16/03)	Missing/incomplete/invalid total charges.	**152**	**TOTAL CHARGE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M54 (10/16/03)	Missing/incomplete/invalid total charges.	**153**	**CLAIM PAYMENT MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M56 (10/16/03)	Missing/incomplete/invalid payer identifier.	**172**	**PAYOR ID MISSING/INVALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	**017**	**SERVICE THRU DATE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (10/01/11)	Missing/incomplete/invalid 'to' date(s) of service.	**019**	**SERVICE PERIOD IS MORE THAN 3 YEARS OLD**	29 (10/01/11)	The time limit for filing has expired.
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	**020**	**SERVICE THRU DATE > DATE RECEIVED**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M59 (04/01/12)	Missing/incomplete/invalid 'to' date(s) of service.	**021**	**INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD**	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.)
M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.	**072**	**STATEMENT COVERS THRU DATE MISSING/INV**	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.
M64 (10/01/14)	Missing/incomplete/invalid other diagnosis.	**416**	**ICD VERSION MISMATCH**	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.
M76 (02/16/15)	Missing/incomplete/invalid diagnosis or condition.	**963**	**CLAIM CHECK: INVALID DIAGNOSIS CODE**	146 (02/16/15)	Diagnosis was invalid for the date(s) of service reported.
M76 (02/16/15)	Missing/incomplete/invalid diagnosis or condition.	**965**	**CLAIM CHECK: INVALID CLAIM DIAGNOSIS CODE**	146 (02/16/15)	Diagnosis was invalid for the date(s) of service reported.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M77 (10/16/03)	Missing/incomplete/invalid/inappropriate place of service.	**141**	**PLACE OF SERVICE MISSING/INVALID**	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.
M79 (11/01/15)	Missing/incomplete/invalid charge.	**151**	**CLAIM CHARGE MISSING/INVALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M81 (10/01/14)	You are required to code to the highest level of specificity.	**428**	**UNSPECIFIED DIAGNOSIS CODE**	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.
M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.	**926**	**CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE**	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.
M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.	**940**	**CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)**	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.
M86 (02/16/15)	Service denied because payment already made for same/similar procedure within set time frame.	**955**	**CLAIM CHECK: DUPLICATE 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.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**127**	**NATIONAL DRUG CODE MISSING OR INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M119 (10/27/14)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**214**	**INVALID NDC OR NDC NOT ON FILE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**330**	**METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG 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.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**545**	**NATIONAL DRUG CODE NOT ON FILE**	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.
M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**553**	**COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**554**	**COMPOUND CONTAINS DUPLICATE INGREDIENTS**	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.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M119 (11/01/15)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**597**	**VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) 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.
M123 (11/01/15)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	**126**	**COMPOUND DRUG INDICATOR MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M123 (10/27/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	**300**	**MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M123 (10/27/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	**317**	**INVALID/MISSING METRIC QUANTITY**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
M127 (11/01/15)	Missing patient medical record for this service.	**123**	**MEDICAL RECORD NUMBER MISSING/INVALID**	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).
M144 (02/16/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**950**	**CLAIM CHECK: POST OPERATIVE PROCEDURE CODE**	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.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
M144 (02/16/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	**951**	**CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE**	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.
M199 (10/27/14)		**544**	**DRUG NOT PAYABLE FEDERAL DESI**	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.
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.	**184**	**ADJUSTMENT REASON CODE MISSING/INVALID**	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.
MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.	**124**	**PATIENT ACCOUNT NUMBER MISSING/INVALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA30 (11/01/15)	Missing/incomplete/invalid type of bill.	**042**	**TYPE OF BILL CODE MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (05/04/09)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**023**	**VOID MATCHED MULTIPLE ENCOUNTERS**	110 (05/04/09)	Billing date predates service date.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**073**	**SERVICE COVERS FROM DATE < STATEMENT FROM DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**074**	**STATEMENT COVERS FROM DATE > SERVICE THRU DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**089**	**DATE OF SURGERY > SERVICE/STATEMENT THRU DATE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.	**400**	**RECIPIENT NOT IN HMO ON DATE OF SERVICE**	109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
MA41 (10/16/03)	Missing/incomplete/invalid admission type.	**044**	**ADMISSION TYPE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA42 (10/16/03)	Missing/incomplete/invalid admission source.	**068**	**ADMISSION SOURCE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA43 (10/16/03)	Missing/incomplete/invalid patient status.	**045**	**PATIENT STATUS CODE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA61 (11/01/15)	Missing/incomplete/invalid social security number.	**321**	**RECIPIENT NUMBER NOT ON FILE**	31 (11/01/15)	Patient cannot be identified as our insured.
MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.	**166**	**DIAGNOSIS CODE MISSING/INVALID**	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.
MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.	**167**	**DIAGNOSIS CODE MISSING**	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.
MA63 (10/16/03)	Missing/incomplete/invalid principal diagnosis.	**296**	**DIAGNOSIS CODE NOT ON FILE**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA65 (09/01/20)	Missing/incomplete/invalid admitting diagnosis.	**289**	**ADMITTING DIAGNOSIS CODE NOT ON FILE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**161**	**PROCEDURE CODE MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**248**	**SURGICAL PROCEDURE CODE NOT ON FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.	**253**	**PROCEDURE NOT VALID ON 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.
MA67 (10/16/03)	Alert: Correction to a prior claim.	**788**	**VOID REQUEST DENIED AGAINST RECONCILED CLAIM**	B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.
MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.	**001**	**INCORRECT CLAIM STATUS CODE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA90 (11/01/15)	Missing/incomplete/invalid employment status code for the primary insured.	**133**	**EMPLOYMENT RELATED INDICTOR MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA102 (01/01/14)	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.	**010**	**SERVICING PROVIDER MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**086**	**ASSISTED LIVING SERVICE UNITS NOT EQUAL TO SERVICE DAYS**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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.	**319**	**MISSING OR INVALID PRESENT ON ADMISSION INDICATOR**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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.	**320**	**POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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.	**451**	**UNKNOWN FIELD POPULATED WITH INVALID DATA**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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.	**464**	**PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**601**	**NO ADJUSTMENT ALLOWED FOR MEDIA 7 ELIGIBLE CLAIMS**	16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**603**	**MOTHER VS. BABY CLAIM. NEWBORN INDICATORS DO NOT MATCH**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA130 (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.	**709**	**MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS**	133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
MA130 (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.	**727**	**CLAIM VOIDED/ADJ FOR REBATE UNIT (OIG AUDIT 2019)**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**728**	**415-DF NUMBER OF REFILLS AUTHORIZED IS NOT NUMERIC**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**729**	**DATE RX WRITTEN > 30 DAYS SCHED II-V**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**730**	**DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG**	175 (09/20/20)	Prescription is incomplete.

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**731**	**460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**732**	**QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**733**	**QTY DISPENSED > QTY PRESCRIBED**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**734**	**NUM OF REFILLS AUTH > O SCHED II**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**735**	**403-D3 FILL NUMBER M/I**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**738**	**343-HD DISPENSING STATUS INVALID**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**740**	**ACCUM O MED EXCEEDS 30 DAYS SUPPLY**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**741**	**M/I INCENTIVE AMOUNT SUBMITTED FIELD (438-E3)**	175 (12/01/20)	Prescription is incomplete.

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**742**	**M/I PROFESSIONAL SERVICE CODE (445-E5)**	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**743**	**M/I SUBMISSION CLARIFICATIONE CODE (420-DK)**	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**744**	**COVID VACCINE ADMINISTRATION CONFLICT**	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**745**	**VACCINE ADMINISTRATION EXCEEDED FOR MEMBER**	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**746**	**MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES**	175 (12/01/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**747**	**EXCEEDS PROG MAX-GREATER THAN SIX FILLS 6 IN A MONTH PERIOD**	175 (04/26/21)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**748**	**DATE RX WRITTEN > 30 DAYS OLD SCHED II - V**	175 (09/20/20)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**749**	**DAILY MORPHINE MILLIGRAM EQUIVALENT > 50**	175 (06/06/22)	Prescription is incomplete.

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**750**	**DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED**	175 (06/06/22)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**753**	**OTC COVID TEST LIMIT EXCEEDED- LIMIT 4 KITS PER MONTH**	175 (02/28/22)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**754**	**BYPASS OF MED EXCEEDS 30 DAYS SUPPLY**	175 (12/01/23)	Prescription is incomplete.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**755**	**SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**785**	**ENCOUNTER INCLUDED IN PAST FINANCIAL SETTLEMENT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**786**	**PREVIOUSLY DENIED CLM CANNOT BE ADJUSTED-RESUBMIT CLAIM**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**787**	**ADJUSTMENT CLM TYPE NOT MATCHED**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (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.	**789**	**INCENTIVE PAYMENT SUPPRESSED AGAINST RECONCILED CLAIM**	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.
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.	**806**	**INPATIENT AND OUTPATIENT DUPLICATE ERROR**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	**808**	**AMDC/INPATIENT CLAIM DATE CONFLICT**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N3 (01/01/16)	Missing consent form.	**826**	**TIMELY FILLING DETERMINED BY PREVIOUS CLAIM**	163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.
N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.	**798**	**HISTORY RECORD ALREADY ADJUSTED OR VOIDED**	18 (01/01/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N30 (07/03/23)	Patient ineligible for this service.	**028**	**PPP SERVICE SUBMITTED AS OVERTIME DENIED.**	28 (07/03/23)	Coverage not in effect at the time the service was provided.
N30 (11/01/15)	Patient ineligible for this service.	**144**	**PATIENT ACCOUNT NUMBER IDENTIFIES HMO-DENIED CLAIM**	B1 (11/01/15)	Non-covered visits.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N30 (10/16/03)	Patient ineligible for this service.	**301**	**RECIPIENT INELIGIBLE ON DATES OF SERVICE**	26 (11/01/15)	Expenses incurred prior to coverage.
N30 (01/02/25)	Patient ineligible for this service.	**326**	**RECIPIENT NOT ELIGIBLE FOR MFP SERVICES AND GOODS**	26 (01/02/25)	Expenses incurred prior to coverage.
N30 (10/16/03)	Patient ineligible for this service.	**385**	**LOGISTICARE TRANSPORTATION SERVICE NOT COVERED FOR RECIPIENT**	96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	**233**	**NPI IS MISSING FOR PRESCRIBING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.	**234**	**NPI IS INVALID FOR PRESCRIBING PROVIDER**	207 (11/01/15)	National Provider identifier - Invalid format
N31 (07/01/08)	Missing/incomplete/invalid prescribing provider identifier.	**272**	**PRESCRIBING NPI SAME AS BILLING/SERVICING NPI**	206 (11/01/15)	National Provider Identifier - missing.
N31 (01/01/19)	Missing/incomplete/invalid prescribing provider identifier.	**726**	**SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N45 (04/01/17)	Payment based on authorized amount.	**724**	**CLAIM SUBMITTED AS A 340B CLAIM**	119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.
N45 (01/01/18)	Payment based on authorized amount.	**725**	**CLAIM VOIDED/ADJUSTED DUE TO INCORRECT HMO PAYMENT AMOUNT**	119 (01/01/18)	Benefit maximum for this time period or occurrence has been reached.

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HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N57 (10/16/03)	Missing/incomplete/invalid prescribing date.	**025**	**DISPENSE DATE INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N57 (10/16/03)	Missing/incomplete/invalid prescribing date.	**131**	**PRESCRIPTION NUMBER MISSING/INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N77 (10/16/03)	Missing/incomplete/invalid designated provider number.	**003**	**PROCEDURE CODE/CAPITATION PROVIDER TYPE UNMATCHED**	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.
N77 (08/16/10)	Missing/incomplete/invalid designated provider number.	**329**	**HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION**	208 (08/16/10)	National Provider Identifier - Not matched.
N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.	**139**	**EPSDT INDICTOR INVALID**	251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
N95 (11/01/15)	This provider type/provider specialty may not bill this service.	**448**	**SUBMITTER NOT ELIGIBLE FOR CLM TYPE OR DOS < 20110701**	185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N95 (12/22/14)	This provider type/provider specialty may not bill this service.	**705**	**PAYMENT DENIED; VACCINE AVAILABLE FROM THE VFC PROGRAM**	175 (05/10/22)	Prescription is incomplete.
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.	**027**	**NO MATCHING CLAIM FOR ENC VOID/ADJ ON PHARMACY VSAM FILE**	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.)

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
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.	**263**	**NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE**	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.
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.	**255**	**PROCEDURE CODE AND SEX RESTRICTION.**	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.
N122 (12/01/22)	Add-on code cannot be billed by itself.	**958**	**CLAIMSXTEN ADD ON EDIT**	B15 (12/01/22)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (11/01/15)	Not eligible due to the patient's age.	**254**	**PROCEDURE CODE AND AGE RESTRICTED**	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.
N129 (01/01/21)	Not eligible due to the patient's age.	**805**	**DOULA VISIT EXCEEDS AGE LIMIT**	6 (01/01/21)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N129 (02/16/15)	Not eligible due to the patient's age.	**929**	**CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT**	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.
N129 (02/16/15)	Not eligible due to the patient's age.	**930**	**CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT**	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.

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N129 (02/16/15)	Not eligible due to the patient's age.	**931**	**CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT**	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.
N129 (02/16/15)	Not eligible due to the patient's age.	**932**	**CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT**	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.
N129 (02/16/15)	Not eligible due to the patient's age.	**941**	**CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED**	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.
N157 (11/01/15)	Transportation to/from this destination is not covered.	**142**	**ORIGIN CODE MISSING/INVALID**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N157 (11/01/15)	Transportation to/from this destination is not covered.	**143**	**DESTINATION CODE MISSING/INVALID**	96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N207 (11/01/15)	Missing/incomplete/invalid weight.	**043**	**INVALID/MISSING BIRTH WEIGHT**	240 (11/01/15)	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N208 (11/01/15)	Missing/incomplete/invalid DRG code.	**479**	**GROUPER COULD NOT ASSIGN A 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.
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**048**	**SURGICAL PROCEDURE CODE MISSING/INVALID**	250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**083**	**SURGICAL PROCEDURE CODE MISSING**	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).
N214 (01/01/16)	Missing/incomplete/invalid history of the related initial surgical procedure(s).	**799**	**NO CLAIM IN HISTORY FILE MATCHES ADJUSTMENT**	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).
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.	**339**	**RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS**	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.
N219 (07/01/12)	Payment based on previous payer's allowed amount.	**911**	**MANAGED CARE SUB-VENDOR REPORTING CAPITATED PAYMENT**	23 (07/01/12)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
N247 (02/16/15)	Missing/incomplete/invalid assistant surgeon taxonomy.	**942**	**CLAIM CHECK: ASSISTANT SURGEON DENIED**	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.
N247 (02/16/15)	Missing/incomplete/invalid assistant surgeon taxonomy.	**943**	**CLAIM CHECK: ASSISTANT AT SURGERY DENIED**	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.
N253 (05/23/07)	Missing/incomplete/invalid attending provider primary identifier.	**223**	**NPI MISSING FOR THE ATTENDING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N253 (05/23/07)	Missing/incomplete/invalid attending provider primary identifier.	**224**	**NPI IS INVALID FOR THE ATTENDING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.	**269**	**ATTENDING NPI SAME AS BILLING/SERVICING NPI**	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.	**217**	**TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.	**218**	**TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.	**298**	**TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N255 (01/01/16)	Missing/incomplete/invalid billing provider taxonomy.	**796**	**SUBMITTER NOT MATCHED ON HISTORY**	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.
N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary identifier.	**206**	**BILLING PROVIDER NUMBER NOT ON FILE**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N261 (11/01/15)	Missing/incomplete/invalid operating provider name.	**087**	**SURGICAL PROVIDER NPI MISSING**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (05/23/07)	Missing/incomplete/invalid operating provider primary identifier.	**227**	**NPI IS MISSING FOR THE OPERATING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N262 (05/23/07)	Missing/incomplete/invalid operating provider primary identifier.	**228**	**NPI IS INVALID FOR THE OPERATING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N262 (09/28/15)	Missing/incomplete/invalid operating provider primary identifier.	**281**	**OPERATING 1 NPI SAME AS BILLING/SERVICING NPI**	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.
N265 (05/23/07)	Missing/incomplete/invalid ordering provider primary identifier.	**229**	**NPI IS MISSING FOR BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N265 (05/23/07)	Missing/incomplete/invalid ordering provider primary identifier.	**230**	**NPI IS INVALID FOR BILLING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	**231**	**NPI IS MISSING FOR OTHER PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.	**232**	**NPI IS INVALID FOR OTHER PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.	**271**	**OTHER NPI SAME AS BILLING/SERVICING NPI**	16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N282 (02/01/19)	Missing/incomplete/invalid pay-to provider secondary identifier.	**011**	**RECIPIENT NUMBER MISSING OR INVALID**	16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N284 (11/01/15)	Missing/incomplete/invalid referring provider taxonomy.	**299**	**TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (11/01/15)	Missing/incomplete/invalid referring provider primary identifier.	**006**	**REFERRING/OPERATING/OTHER PROVIDER EIN/SSN INVALID**	208 (11/01/15)	National Provider Identifier - Not matched.
N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.	**225**	**NPI IS MISSING FOR THE REFERRING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.	**226**	**NPI IS INVALID FOR THE REFERRING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N288 (11/01/15)	Missing/incomplete/invalid rendering provider taxonomy.	**110**	**ENC TAXONOMY MISSING/INVALID**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	**219**	**TAXONOMY CODE IS MISSING FOR SERVICE PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.	**220**	**TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	**221**	**NPI IS MISSING FOR SERVICE/RENDERING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.	**222**	**NPI IS INVALID FOR SERVICE/RENDERING PROVIDER**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.	**236**	**ZIP CODE MISSING OR INVALID**	16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.	**297**	**BILLING ZIP CODE MISSING OR INVALID**	16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N301 (02/20/26)	Missing/incomplete/invalid procedure date(s).	**327**	**DISCONTINUED PROC CODES MFP MEDIA 7 PAYMENT**	204 (02/20/26)	This service/equipment/drug is not covered under the patient's current benefit plan
N307 (11/06/06)	Missing/incomplete/invalid adjudication or payment date.	**183**	**HMO PAYMENT DATE MISSING/INVALID**	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.
N324 (01/01/14)	Missing/incomplete/invalid last seen/visit date.	**135**	**CURRENT EXAM DATE MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N329 (01/01/14)	Missing/incomplete/invalid patient birth date.	**013**	**INVALID BIRTHDATE**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N341 (11/01/15)	Missing/incomplete/invalid surgery date.	**049**	**SURGICAL DATE MISSING/INVALID**	16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N342 (11/01/15)	Missing/incomplete/invalid test performed date.	**136**	**PREVIOUS EXAM DATE INV**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N345 (02/16/15)	Date range not valid with units submitted.	**959**	**CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS**	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.
N345 (02/16/15)	Date range not valid with units submitted.	**960**	**CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS**	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.
N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	**803**	**POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D**	272 (01/01/21)	Coverage/program guidelines were not met.
N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.	**197**	**COMPOUND DRUG OR METRIC QUANTITY ERROR**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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Encounter Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 9/7/2026

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N378 (10/27/14)	Missing/incomplete/invalid prescription quantity.	**349**	**VERIFY METRIC QUANTITY REPORTED**	16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382 (11/01/15)	Missing/incomplete/invalid patient identifier.	**101**	**ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK**	016 (11/01/19)	
N383 (02/16/15)	Not covered when deemed cosmetic.	**920**	**CLAIM CHECK: COSMETIC PROCEDURE**	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.
N383 (02/16/15)	Not covered when deemed cosmetic.	**922**	**CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED**	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.
N389 (11/02/09)	Duplicate prescription number submitted.	**024**	**DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER/NDC**	18 (11/02/09)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	**130**	**PHARMACY DAYS SUPPLY MISSING/INVALID**	204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan
N517 (02/16/15)	Resubmit a new claim with the requested information.	**933**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE**	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.
N517 (02/16/15)	Resubmit a new claim with the requested information.	**934**	**CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE**	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.
N517 (02/16/15)	Resubmit a new claim with the requested information.	**953**	**CLAIM CHECK: PROCEDURE GENDER RESTRICTION**	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.
N519 (01/01/14)	Invalid combination of HCPCS modifiers.	**162**	**PROCEDURE CODE MODIFIER MISSING/INVALID**	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.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N519 (02/16/15)	Invalid combination of HCPCS modifiers.	**961**	**CLAIM CHECK: INVALID MODIFIER**	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.
N522 (01/01/16)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**797**	**DUPLICATE ADJUSTMENT**	18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**800**	**EXACT DUPLICATE BILL**	18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N522 (08/29/25)	Duplicate of a claim processed, or to be processed, as a crossover claim.	**807**	**INPATIENT TO INPATIENT POSSIBLE DUPLICATE ERROR**	18 (08/25/25)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
N569 (01/01/21)	Not covered when performed for the reported diagnosis.	**425**	**INVALID DIAGNOSIS FOR SERVICE**	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.
N569 (01/01/21)	Not covered when performed for the reported diagnosis.	**802**	**DOULA VISITS EXCEED LIMIT**	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.
N569 (12/01/22)	Not covered when performed for the reported diagnosis.	**969**	**CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE**	A1 (12/01/22)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.
N576 (11/01/15)	Services not related to the specific incident/claim/accident/loss being reported.	**138**	**ACCIDENT INDICTOR MISSING/INVALID**	109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
N622 (11/01/15)	Not covered based on the date of injury/accident.	**064**	**SERVICE THRU DATE > STATEMENT THRU DATE**	110 (11/01/15)	Billing date predates service date.
N623 (11/01/15)	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	**555**	**COMPOUND DRUG - INCORRECT INGREDIENT QUANTITY/COST**	114 (11/01/15)	Procedure/product not approved by the Food and Drug Administration.
N623 (11/01/15)	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	**556**	**INVALID COMPOUND - CONTAINS ONE INGREDIENT + WATER**	114 (11/01/15)	Procedure/product not approved by the Food and Drug Administration.

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N644 (11/01/15)	Reimbursement has been made according to the bilateral procedure rule.	**310**	**HMO SENT 'M' TO REQUEST MEDIA 7 KICK PAYMENT AND MMIS PAID**	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.
N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).	**480**	**GROUPER ASSIGNED A NEW DRG CODE**	A8 (11/01/15)	Ungroupable DRG.
N649 (10/01/20)	Payment based on invoice.	**014**	**PPP SERVICE SUBMITTED AS OVERTIME**	120 (10/01/20)	Patient is covered by a managed care plan.
N657 (11/01/15)	This should be billed with the appropriate code for these services.	**312**	**MEDIA 7 CONFLICT RECIPIENT MHC PAYMENT CODE MISSING/INVAL**	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.
N661 (08/01/20)	Documentation does not support that the services rendered were medically necessary.	**426**	**EARLY ELECTIVE DELIVERY**	50 (08/01/20)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.	**427**	**EARLY ELECTIVE DELIVERY DENIAL OVERRIDE**	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.
N666 (01/01/16)	Only one evaluation and management code at this service level is covered during the course of care.	**871**	**MEDIA 7 SERVICE LIMIT ERROR**	204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan
N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.	**804**	**DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS**	B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N705 (12/07/20)	Incomplete/invalid documentation.	**459**	**PRA INVALID - NO RECIPIENT FOUND FOR PRENATAL SERVICE**	226 (12/07/20)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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Encounter Edit Codes/HIPAA Edit Codes Translation -

Sequenced by HIPAA Remark Code

Last Date Loaded - 9/7/2026

HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description	Encounter Edit Code	Encounter Edit Code Description	HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description
N705 (08/16/21)	Incomplete/invalid documentation.	**465**	**PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS**	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.)
N822 (12/01/22)	Missing procedure modifier(s).	**968**	**CLAIMSXTEN: MISSING MODIFIER 26**	4 (12/01/22)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.