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- Mapped Med-QUEST Claim Edit/Result Code values appear in Edit/Result Code sequence. Med-QUEST Claim Reason Codes are mapped separately.
- Result Codes are single-character codes that further define HPMMIS edits. They appear after the Edit Code decimal point and vary by Edit Type.
- One of the first five Adjustment Reason Code values documented at the beginning of this matrix will always appear as an initial Adjustment Reason Code when there has been a claim or service line level "adjustment" to the Charged Amount. For payer initiated adjustments (Claim Adjustment Group Code = "PI"), additional Adjustment Reason Codes, if generated from HPMMIS Reason and Edit/Result Codes, will appear on 835 Transactions with zero Adjustment Amounts. Remark Codes will appear whenever HPMMIS Reason Codes translate to them.
- When the Paid Amount is the same as the Billed Amount, no 835 Adjustment Reason Code is needed.

MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
	ADJUSTMENT REASON CODE FOR SHARE OF COST PAYMENTS AND OTHER PATIENT CONTRIBUTIONS (Claim Adjustment Group Code [CAS01] = "PR" [Patient Responsibility])	**3**	**Co-payment Amount** Each Adjustment Amount within a "PR" CAS Segment represents a separate payment applied to the claim.		
	ADJUSTMENT REASON CODE FOR PAYMENTS MADE BY OTHER CARRIERS (Claim Adjustment Group Code [CAS01] = "OA" [Other Adjustments])	**22**	**Payment adjusted because this care may be covered by another payer per coordination of benefits.** Each Adjustment Amount within an "OA" CAS Segment represents a separate payment for this claim.		
	ADJUSTMENT REASON CODE FOR PREVIOUS PAYMENTS BY MED-QUEST (Claim Adjustment Group Code [CAS01] = "OA" [Other Adjustments])	**B13**	**Previously paid. Payment for this claim/service may have been provided in a previous payment.** Each Adjustment Amount within an "OA" CAS Segment represents a separate payment for this claim.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
	INITIAL ADJUSTMENT REASON CODE FOR CLAIM OR SERVICE LINE DENIALS (Claim Adjustment Group Code [CAS01] = "PI" [Payer Initiated Reductions])	**A1**	**Claim denied charges.** The initial Adjustment Amount within a "PI" CAS Segment for a denied claim or service line is the same as the corresponding Charged Amount. Any subsequent Adjustment Reason Codes that have been translated from Med-QUEST Reason and Edit/Result Codes appear with zero Adjustment Amounts.		
	INITIAL ADJUSTMENT REASON CODE FOR ADJUSTED PAYMENTS THAT ARE LESS THAN CHARGED AMOUNTS (Claim Adjustment Group Code [CAS01] = "PI" [Payer Initiated Reductions])	**A2**	**Contractual Adjustment** The initial Adjustment Amount within a "PI" CAS Segment when a claim or service line payment reduction is greater than zero but less than the corresponding Charged Amount. Any subsequent Adjustment Reason Codes that have been translated from MED-QUEST Reason and Edit/Result Codes appear with zero Adjustment Amounts.		
One of the five Adjustment Reason Codes listed above will always appear as the initial Adjustment Reason Code when a claim or service line is "adjusted" (i.e., paid at less than the Charged Amount). Initial Adjustment Reason Codes are generated from claim conditions. Following the initial Code, additional Adjustment Reason Codes translated from the mapping can be added within CAS Segments. For subsequent Adjustment Reason Codes, Adjustment Amounts are always zero and Adjustment Quantities are absent. Designated Remark Codes also appear on 835 Transactions but are not associated with payments.					
H001.1	SERVICE PROVIDER ID FIELD IS MISSING	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		
H001.2	SERVICE PROVIDER ID FIELD IS INVALID FORMAT	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H001.3	SERVICE PROVIDER ID FIELD IS NOT ON FILE	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		
H001.5	SERVICE PROVIDER ID CANNOT BE GROUP PAYMENT ID	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		
H001.6	SERVICE PROVIDER ID TEST MUST BE SCHOOL DISTRICT	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/perform the service billed.		
H002.1	RECIPIENT ID FIELD IS MISSING			MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number.
H002.2	RECIPIENT ID FIELD IS INVALID FORMAT			MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number.
H002.3	RECIPIENT ID FIELD IS NOT ON FILE	31	Claim denied as patient cannot be identified as our insured.		
H002.4	RECIPIENT ID MULTIPLE MATCHES IDENTIFIED	31	Claim denied as patient cannot be identified as our insured.		
H003.1	ADMISSION DATE IS MISSING			MA40	Incomplete/invalid admission date.
H003.2	ADMISSION DATE HAS INVALID FORMAT			MA40	Incomplete/invalid admission date.
H003.3	ADMISSION DATE IS NOT POSSIBLE			MA40	Incomplete/invalid admission date.
H003.4	ADMISSION DATE IS IN THE FUTURE			MA40	Incomplete/invalid admission date.
H004.1	UB92 SERVICE BEGIN DATE DATE IS MISSING			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H004.2	UB92 SERVICE BEGIN DATE DATA HAS INVALID FORMAT			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H004.3	UB92 SERVICE BEGIN DATE DATE IS NOT POSSIBLE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H004.4	UB92 SERVICE BEGIN DATE DATE IS IN THE FUTURE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H005.1	UB92 SERVICE END DATE DATE IS MISSING			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H005.2	UB92 SERVICE END DATE DATE HAS INVALID FORMAT			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H005.3	UB92 SERVICE END DATE DATE IS NOT POSSIBLE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H005.4	UB92 SERVICE END DATE DATE IS IN THE FUTURE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H006.1	UB92 SERVICE BEGIN VS SERVICE END DATE #2 IS PRIOR TO #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H007.1	10/01/82 VS UB92 SERVICE BEGIN DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H008.1	UB92 SERVICE END VS CLAIM RECEIPT DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H009.1	UB92 SERVICE BEGIN DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service		
H009.2	UB92 SERVICE BEGIN DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		
H010.1	UB92 SERVICE END DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.		
H010.2	UB92 SERVICE END DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H011.1	ADMISSION HOUR CODE IS MISSING			N46	Missing/incomplete/invalid admission hour.
H011.2	ADMISSION HOUR CODE IS INVALID			N46	Missing/incomplete/invalid admission hour.
H012.1	ADMISSION TYPE CODE IS MISSING			MA41	Incomplete/invalid type of admission.
H012.2	ADMISSION TYPE CODE IS INVALID			MA41	Incomplete/invalid type of admission.
H013.1	ADMISSION SOURCE CODE IS MISSING			MA42	Incomplete/invalid source of admission.
H013.2	ADMISSION SOURCE CODE IS INVALID			MA42	Incomplete/invalid source of admission.
H014.1	DISCHARGE HOUR CODE IS MISSING			N50	Discharge information missing/incomplete/incorrect/invalid.
H014.2	DISCHARGE HOUR CODE IS INVALID			N50	Discharge information missing/incomplete/incorrect/invalid.
H015.1	PATIENT STATUS CODE IS MISSING			MA43	Incomplete/invalid patient status.
H015.2	PATIENT STATUS CODE IS INVALID			MA43	Incomplete/invalid patient status.
H016.2	CONDITION CODE #1 CODE IS INVALID			M44	Incomplete/invalid condition code.
H017.2	CONDITION CODE #2 CODE IS INVALID			M44	Incomplete/invalid condition code.
H018.2	CONDITION CODE #3 CODE IS INVALID			M44	Incomplete/invalid condition code.
H019.2	CONDITION CODE #4 CODE IS INVALID			M44	Incomplete/invalid condition code.
H020.2	CONDITION CODE #5 CODE IS INVALID			M44	Incomplete/invalid condition code.
H021.2	CONDITION CODE #6 CODE IS INVALID			M44	Incomplete/invalid condition code.
H022.2	CONDITION CODE #7 CODE IS INVALID			M44	Incomplete/invalid condition code.
H023.2	OCCURRENCE CODE #1 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H024.2	OCCURRENCE CODE #2 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H025.2	OCCURRENCE CODE #3 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H026.2	OCCURRENCE CODE #4 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H027.2	OCCURRENCE CODE #5 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H028.2	OCCURRENCE CODE #6 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H029.2	OCCURRENCE CODE #7 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H030.2	OCCURRENCE CODE #8 CODE IS INVALID			M45	Incomplete/invalid occurrence codes and dates.
H031.2	OCCURRENCE SPAN CODE #1 CODE IS INVALID			M46	Incomplete/invalid occurrence span codes and dates.
H032.2	OCCURRENCE SPAN CODE #2 CODE IS INVALID			M46	Incomplete/invalid occurrence span codes and dates.
H033.2	VALUE CODE #1 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H034.2	VALUE CODE #2 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H035.2	VALUE CODE #3 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H036.2	VALUE CODE #4 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H037.2	VALUE CODE #5 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H038.2	VALUE CODE #6 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H039.2	VALUE CODE #7 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H040.2	VALUE CODE #8 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H041.2	VALUE CODE #9 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H042.2	VALUE CODE #10 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H043.2	VALUE CODE #11 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H044.2	VALUE CODE #12 CODE IS INVALID			M49	Incomplete/invalid value code(s) and/or amount(s).
H045.1	OCCURRENCE DATE #1 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H045.2	OCCURRENCE DATE #1 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H045.3	OCCURRENCE DATE #1 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H045.4	OCCURRENCE DATE #1 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H046.1	OCCURRENCE DATE #2 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H046.2	OCCURRENCE DATE #2 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H046.3	OCCURRENCE DATE #2 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H046.4	OCCURRENCE DATE #2 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H047.1	OCCURRENCE DATE #3 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H047.2	OCCURRENCE DATE #3 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H047.3	OCCURRENCE DATE #3 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H047.4	OCCURRENCE DATE #3 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H048.1	OCCURRENCE DATE #4 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H048.2	OCCURRENCE DATE #4 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H048.3	OCCURRENCE DATE #4 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H048.4	OCCURRENCE DATE #4 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H049.1	OCCURRENCE DATE #5 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H049.2	OCCURRENCE DATE #5 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H049.3	OCCURRENCE DATE #5 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H049.4	OCCURRENCE DATE #5 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H050.1	OCCURRENCE DATE #6 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H050.2	OCCURRENCE DATE #6 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H050.3	OCCURRENCE DATE #6 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H050.4	OCCURRENCE DATE #6 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H051.1	OCCURRENCE DATE #7 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H051.2	OCCURRENCE DATE #7 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H051.3	OCCURRENCE DATE #7 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H051.4	OCCURRENCE DATE #7 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.
H052.1	OCCURRENCE DATE #8 IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H052.2	OCCURRENCE DATE #8 HAS INVALID FORMAT			M45	Incomplete/invalid occurrence codes and dates.
H052.3	OCCURRENCE DATE #8 IS NOT POSSIBLE			M45	Incomplete/invalid occurrence codes and dates.
H052.4	OCCURRENCE DATE #8 IS IN THE FUTURE			M45	Incomplete/invalid occurrence codes and dates.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H053.1	OCCURRENCE SPAN FROM DATE #1 DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H053.2	OCCURRENCE SPAN FROM DATE #1 DATE HAS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H053.3	OCCURRENCE SPAN FROM DATE #1 DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H053.4	OCCURRENCE SPAN FROM DATE #1 DATE IS IN THE FUTURE			M46	Incomplete/invalid occurrence span codes and dates.
H054.1	OCCURRENCE SPAN FROM DATE #2 DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H054.2	OCCURRENCE SPAN FROM DATE #2 DATE HAS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H054.3	OCCURRENCE SPAN FROM DATE #2 DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H054.4	OCCURRENCE SPAN FROM DATE #2 DATE IS IN THE FUTURE			M46	Incomplete/invalid occurrence span codes and dates.
H055.1	OCCURRENCE SPAN THRU DATE #1 DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H055.2	OCCURRENCE SPAN THRU DATE #1 DATE HAS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H055.3	OCCURRENCE SPAN THRU DATE #1 DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H055.4	OCCURRENCE SPAN THRU DATE #1 DATE IS IN THE FUTURE			M46	Incomplete/invalid occurrence span codes and dates.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H056.1	OCCURRENCE SPAN THRU DATE #2 DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H056.2	OCCURRENCE SPAN THRU DATE #2 DATE HAS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H056.3	OCCURRENCE SPAN THRU DATE #2 DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H056.4	OCCURRENCE SPAN THRU DATE #2 DATE IS IN THE FUTURE			M46	Incomplete/invalid occurrence span codes and dates.
H057.1	VALUE AMOUNT #1 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H057.2	VALUE AMOUNT #1 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H057.3	VALUE AMOUNT #1 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H057.4	VALUE AMOUNT #1 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H058.1	VALUE AMOUNT #2 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H058.2	VALUE AMOUNT #2 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H058.3	VALUE AMOUNT #2 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H058.4	VALUE AMOUNT #2 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H059.1	VALUE AMOUNT #3 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H059.2	VALUE AMOUNT #3 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H059.3	VALUE AMOUNT #3 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H059.4	VALUE AMOUNT #3 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H060.1	VALUE AMOUNT #4 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H060.2	VALUE AMOUNT #4 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H060.3	VALUE AMOUNT #4 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H060.4	VALUE AMOUNT #4 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H061.1	VALUE AMOUNT #5 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H061.2	VALUE AMOUNT #5 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H061.3	VALUE AMOUNT #5 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H061.4	VALUE AMOUNT #5 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H062.1	VALUE AMOUNT #6 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H062.2	VALUE AMOUNT #6 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H062.3	VALUE AMOUNT #6 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H062.4	VALUE AMOUNT #6 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H063.1	VALUE AMOUNT #7 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H063.2	VALUE AMOUNT #7 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H063.3	VALUE AMOUNT #7 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H063.4	VALUE AMOUNT #7 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H064.1	VALUE AMOUNT #8 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H064.2	VALUE AMOUNT #8 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H064.3	VALUE AMOUNT #8 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H064.4	VALUE AMOUNT #8 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H065.1	VALUE AMOUNT #9 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H065.2	VALUE AMOUNT #9 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H065.3	VALUE AMOUNT #9 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H065.4	VALUE AMOUNT #9 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H066.1	VALUE AMOUNT #10 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H066.2	VALUE AMOUNT #10 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H066.3	VALUE AMOUNT #10 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H066.4	VALUE AMOUNT #10 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H067.1	VALUE AMOUNT #11 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H067.2	VALUE AMOUNT #11 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H067.3	VALUE AMOUNT #11 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H067.4	VALUE AMOUNT #11 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.
H068.1	VALUE AMOUNT #12 FIELD IS MISSING			M49	Incomplete/invalid value codes and/or amounts.
H068.2	VALUE AMOUNT #12 FIELD IS NOT NUMERIC			M49	Incomplete/invalid value codes and/or amounts.
H068.3	VALUE AMOUNT #12 FIELD IS ZERO			M49	Incomplete/invalid value codes and/or amounts.
H068.4	VALUE AMOUNT #12 FIELD IS NEGATIVE			M49	Incomplete/invalid value codes and/or amounts.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H069.2	OCCURRENCE #1 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H069.3	OCCURRENCE #1 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H070.2	OCCURRENCE #2 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H070.3	OCCURRENCE #2 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H071.2	OCCURRENCE #3 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H071.3	OCCURRENCE #3 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H072.2	OCCURRENCE #4 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H072.3	OCCURRENCE #4 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H073.2	OCCURRENCE #5 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H073.3	OCCURRENCE #5 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H074.2	OCCURRENCE #6 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H074.3	OCCURRENCE #6 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H075.2	OCCURRENCE #7 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H075.3	OCCURRENCE #7 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H076.2	OCCURRENCE #8 CODE AND DATE FIRST FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H076.3	OCCURRENCE #8 CODE AND DATE SECOND FIELD IS MISSING			M45	Incomplete/invalid occurrence codes and dates.
H077.1	SERVICE PROVIDER LOCATION CODE IS MISSING			M57	Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H077.2	SERVICE PROVIDER LOCATION CODE IS INVALID			M57	Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
H078.1	BILL TYPE CODE CODE IS MISSING			MA30	Incomplete/invalid type of bill.
H078.2	BILL TYPE CODE CODE IS INVALID			MA30	Incomplete/invalid type of bill.
H079.1	BILLING PROVIDER ID FIELD IS MISSING			M57	Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
H079.2	BILLING PROVIDER ID FIELD IS INVALID FORMAT			M57	Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
H079.3	BILLING PROVIDER ID FIELD IS NOT ON FILE			M57	Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)
H080.1	OCCURRENCE SPAN #1 – SOME DATA INCORRECT CODE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H080.2	OCCURRENCE SPAN #1 – SOME DATA INCORRECT BOTH DATES ARE MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H080.3	OCCURRENCE SPAN #1 – SOME DATA INCORRECT FROM DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H080.4	OCCURRENCE SPAN #1 – SOME DATA INCORRECT THRU DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H080.5	OCCURRENCE SPAN #1 – SOME DATA INCORRECT FROM DATE IS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H080.6	OCCURRENCE SPAN #1 – SOME DATA INCORRECT THRU DATE IS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H080.7	OCCURRENCE SPAN #1 – SOME DATA INCORRECT FROM DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H080.8	OCCURRENCE SPAN #1 – SOME DATA INCORRECT THRU DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H080.9	OCCURRENCE SPAN #1 – SOME DATA INCORRECT THRU DATE PRECEDES FROM DATE			M46	Incomplete/invalid occurrence span codes and dates.
H081.1	OCCURRENCE SPAN #2 – SOME DATA INCORRECT CODE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H081.2	OCCURRENCE SPAN #2 – SOME DATA INCORRECT BOTH DATES ARE MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H081.3	OCCURRENCE SPAN #2 – SOME DATA INCORRECT FROM DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H081.4	OCCURRENCE SPAN #2 – SOME DATA INCORRECT THRU DATE IS MISSING			M46	Incomplete/invalid occurrence span codes and dates.
H081.5	OCCURRENCE SPAN #2 – SOME DATA INCORRECT FROM DATE IS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H081.6	OCCURRENCE SPAN #2 – SOME DATA INCORRECT THRU DATE IS INVALID FORMAT			M46	Incomplete/invalid occurrence span codes and dates.
H081.7	OCCURRENCE SPAN #2 – SOME DATA INCORRECT FROM DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H081.8	OCCURRENCE SPAN #2 – SOME DATA INCORRECT THRU DATE IS NOT POSSIBLE			M46	Incomplete/invalid occurrence span codes and dates.
H081.9	OCCURRENCE SPAN #2 – SOME DATA INCORRECT THRU DATE PRECEDES FROM DATE			M46	Incomplete/invalid occurrence span codes and dates.

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H082.2	VALUE #1 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H082.3	VALUE #1 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H083.2	VALUE #2 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H083.3	VALUE #2 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H084.2	VALUE #3 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H084.3	VALUE #3 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H085.2	VALUE #4 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H085.3	VALUE #4 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H086.2	VALUE #5 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H086.3	VALUE #5 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H087.2	VALUE #6 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H087.3	VALUE #6 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H088.2	VALUE #7 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H088.3	VALUE #7 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H089.2	VALUE #8 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H089.3	VALUE #8 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H090.2	VALUE #9 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H090.3	VALUE #9 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H091.2	VALUE #10 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H091.3	VALUE #10 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H092.2	VALUE #11 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H092.3	VALUE #11 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H093.2	VALUE #12 CODE AND AMOUNT FIRST FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H093.3	VALUE #12 CODE AND AMOUNT SECOND FIELD IS MISSING			M49	Incomplete/invalid value code(s) and/or amount(s).
H094.1	PRIMARY DIAGNOSIS CODE FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Incomplete/invalid principal diagnosis code.
H094.2	PRIMARY DIAGNOSIS CODE FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Incomplete/invalid principal diagnosis code.
H094.3	PRIMARY DIAGNOSIS CODE FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Incomplete/invalid principal diagnosis code.
H095.1	DIAGNOSIS CODE #2 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H095.2	DIAGNOSIS CODE #2 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H095.3	DIAGNOSIS CODE #2 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H096.1	DIAGNOSIS CODE #3 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H096.2	DIAGNOSIS CODE #3 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H096.3	DIAGNOSIS CODE #3 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H097.1	DIAGNOSIS CODE #4 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H097.2	DIAGNOSIS CODE #4 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H097.3	DIAGNOSIS CODE #4 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H098.1	DIAGNOSIS CODE #5 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H098.2	DIAGNOSIS CODE #5 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H098.3	DIAGNOSIS CODE #5 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H099.1	DIAGNOSIS CODE #6 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H099.2	DIAGNOSIS CODE #6 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H099.3	DIAGNOSIS CODE #6 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H100.1	DIAGNOSIS CODE #7 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H100.2	DIAGNOSIS CODE #7 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H100.3	DIAGNOSIS CODE #7 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H101.1	DIAGNOSIS CODE #8 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H101.2	DIAGNOSIS CODE #8 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H101.3	DIAGNOSIS CODE #8 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H102.1	DIAGNOSIS CODE #9 FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H102.2	DIAGNOSIS CODE #9 FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H102.3	DIAGNOSIS CODE #9 FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H103.1	ADMISSION DIAGNOSIS CODE FIELD IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H103.2	ADMISSION DIAGNOSIS CODE FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H103.3	ADMISSION DIAGNOSIS CODE FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H104.2	EMERGENCY DIAGNOSIS CODE FIELD IS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H104.3	EMERGENCY DIAGNOSIS CODE FIELD IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H105.1	ADMIT DATE VS SERVICE BEGIN DATE DATE #2 IS PRIOR TO DATE #1			MA40	Incomplete/invalid admission date.
H106.1	ICD9 PROCEDURE CODE #1 FIELD IS MISSING			MA66	Incomplete/invalid principal procedure code and/or date.
H106.2	ICD9 PROCEDURE CODE #1 FIELD IS INVALID FORMAT			MA66	Incomplete/invalid principal procedure code and/or date.
H106.3	ICD9 PROCEDURE CODE #1 FIELD IS NOT ON FILE			MA66	Incomplete/invalid principal procedure code and/or date.
H107.1	ICD9 PROCEDURE CODE #2 FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H107.2	ICD9 PROCEDURE CODE #2 FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H107.3	ICD9 PROCEDURE CODE #2 FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H108.1	ICD9 PROCEDURE CODE #3 FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H108.2	ICD9 PROCEDURE CODE #3 FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H108.3	ICD9 PROCEDURE CODE #3 FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H109.1	ICD9 PROCEDURE CODE #4 FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H109.2	ICD9 PROCEDURE CODE #4 FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H109.3	ICD9 PROCEDURE CODE #4 FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H110.1	ICD9 PROCEDURE CODE #5 FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H110.2	ICD9 PROCEDURE CODE #5 FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H110.3	ICD9 PROCEDURE CODE #5 FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H111.1	ICD9 PROCEDURE CODE #6 FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H111.2	ICD9 PROCEDURE CODE #6 FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H111.3	ICD9 PROCEDURE CODE #6 FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H112.1	ICD9 PROCEDURE DATE #1 DATE IS MISSING			MA66	Incomplete/invalid principal procedure code and/or date.
H112.2	ICD9 PROCEDURE DATE #1 DATE HAS INVALID FORMAT			MA66	Incomplete/invalid principal procedure code and/or date.
H112.3	ICD9 PROCEDURE DATE #1 DATE IS NOT POSSIBLE			MA66	Incomplete/invalid principal procedure code and/or date.
H112.4	ICD9 PROCEDURE CODE #1 DATE IS IN THE FUTURE			MA66	Incomplete/invalid principal procedure code and/or date.
H113.1	ICD9 PROCEDURE DATE #2 DATE IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H113.2	ICD9 PROCEDURE DATE #2 DATE HAS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H113.3	ICD9 PROCEDURE DATE #2 DATE IS NOT POSSIBLE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H113.4	ICD9 PROCEDURE CODE #2 DATE IS IN THE FUTURE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H114.1	ICD9 PROCEDURE DATE #3 DATE IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H114.2	ICD9 PROCEDURE DATE #3 DATE HAS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H114.3	ICD9 PROCEDURE DATE #3 DATE IS NOT POSSIBLE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H114.4	ICD9 PROCEDURE DATE #3 DATE IS IN THE FUTURE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H115.1	ICD9 PROCEDURE DATE #4 DATE IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H115.2	ICD9 PROCEDURE DATE #4 DATE HAS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H115.3	ICD9 PROCEDURE DATE #4 DATE IS NOT POSSIBLE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H115.4	ICD9 PROCEDURE DATE #4 DATE IS IN THE FUTURE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H116.1	ICD9 PROCEDURE DATE #5 DATE IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H116.2	ICD9 PROCEDURE DATE #5 DATE HAS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H116.3	ICD9 PROCEDURE DATE #5 DATE IS NOT POSSIBLE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H116.4	ICD9 PROCEDURE DATE #5 DATE IS IN THE FUTURE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H117.1	ICD9 PROCEDURE DATE #6 DATE IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H117.2	ICD9 PROCEDURE DATE #6 DATE HAS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H117.3	ICD9 PROCEDURE DATE #6 DATE IS NOT POSSIBLE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H117.4	ICD9 PROCEDURE DATE #6 DATE IS IN THE FUTURE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H118.2	ICD9 PROCEDURE #1 CODE AND DATE FIRST FIELD IS MISSING			MA66	Incomplete/invalid principal procedure code and/or date.
H118.3	ICD9 PROCEDURE #1 CODE AND DATE SECOND FIELD IS MISSING			MA66	Incomplete/invalid principal procedure code and/or date.
H119.2	ICD9 PROCEDURE #2 CODE AND DATE FIRST FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H119.3	ICD9 PROCEDURE #2 CODE AND DATE SECOND FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H120.2	ICD9 PROCEDURE #3 CODE AND DATE FIRST FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H120.3	ICD9 PROCEDURE #3 CODE AND DATE SECOND FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H121.2	ICD9 PROCEDURE #4 CODE AND DATE FIRST FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H121.3	ICD9 PROCEDURE #4 CODE AND DATE SECOND FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H122.2	ICD9 PROCEDURE #5 CODE AND DATE FIRST FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H122.3	ICD9 PROCEDURE #5 CODE AND DATE SECOND FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H123.2	ICD9 PROCEDURE #6 CODE AND DATE FIRST FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H123.3	ICD9 PROCEDURE #6 CODE AND DATE SECOND FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
H124.1	ATTENDING PROVIDER ID FIELD IS MISSING			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H124.2	ATTENDING PROVIDER ID FIELD IS INVALID FORMAT			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H124.3	ATTENDING PROVIDER ID FIELD IS NOT ON FILE			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H124.5	ATTENDING PROVIDER ID CANNOT BE GROUP-PAYMENT ID	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/perform the service billed.	N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H125.1	REFERRING PROVIDER ID FIELD IS MISSING			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H125.2	REFERRING PROVIDER ID FIELD IS INVALID FORMAT			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H125.3	REFERRING PROVIDER ID FIELD IS NOT ON FILE			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H125.5	REFERRING PROVIDER ID CANNOT BE GROUP-PAYMENT ID			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H126.1	PRESCRIBING PROVIDER ID FIELD IS MISSING			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H126.2	PRESCRIBING PROVIDER ID FIELD IS INVALID FORMAT			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H126.3	PRESCRIBING PROVIDER ID FIELD IS NOT ON FILE	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/perform the service billed.	N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H126.5	PRESCRIBING PROVIDER ID CANNOT BE GROUP-PAYMENT ID			N31	Prescribing/referring/attending practitioner **license** number is absent/incorrect/incomplete.
H128.1	PRIMARY DIAGNOSIS CODE IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H128.2	PRIMARY DIAGNOSIS CODE IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H128.3	PRIMARY DIAGNOSIS CODE IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H129.1	DIAGNOSIS CODE #2 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H129.2	DIAGNOSIS CODE #2 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H129.3	DIAGNOSIS CODE #2 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H130.1	DIAGNOSIS CODE #3 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H130.2	DIAGNOSIS CODE #3 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H130.3	DIAGNOSIS CODE #3 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H131.1	DIAGNOSIS CODE #4 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H131.2	DIAGNOSIS CODE #4 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H131.3	DIAGNOSIS CODE #4 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H132.1	DIAGNOSIS CODE #5 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H132.2	DIAGNOSIS CODE #5 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H132.3	DIAGNOSIS CODE #5 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H133.1	DIAGNOSIS CODE #6 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H133.2	DIAGNOSIS CODE #6 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H133.3	DIAGNOSIS CODE #6 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H134.1	DIAGNOSIS CODE #7 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H134.2	DIAGNOSIS CODE #7 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H134.3	DIAGNOSIS CODE #7 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H135.1	DIAGNOSIS CODE #8 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H135.2	DIAGNOSIS CODE #8 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H135.3	DIAGNOSIS CODE #8 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H136.1	DIAGNOSIS CODE #9 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H136.2	DIAGNOSIS CODE #9 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H136.3	DIAGNOSIS CODE #9 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H137.1	ADMITTING DIAGNOSIS CODE IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H137.2	ADMITTING DIAGNOSIS CODE IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H137.3	ADMITTING DIAGNOSIS CODE IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H138.1	EMERGENCY DIAGNOSIS CODE IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H138.2	EMERGENCY DIAGNOSIS CODE IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H138.3	EMERGENCY DIAGNOSIS CODE IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H140.1	PRIMARY DIAGNOSIS CODE NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H140.2	PRIMARY DIAGNOSIS CODE NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H140.3	PRIMARY DIAGNOSIS CODE NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H140.4	PRIMARY DIAGNOSIS CODE NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H140.5	PRIMARY DIAGNOSIS CODE REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H140.6	PRIMARY DIAGNOSIS CODE REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H140.7	PRIMARY DIAGNOSIS CODE REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H140.9	PRIMARY DIAGNOSIS CODE REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H141.1	DIAGNOSIS CODE #2 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H141.2	DIAGNOSIS CODE #2 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H141.3	DIAGNOSIS CODE #2 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H141.4	DIAGNOSIS CODE #2 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H141.5	DIAGNOSIS CODE #2 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H141.6	DIAGNOSIS CODE #2 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H141.7	DIAGNOSIS CODE #2 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H141.9	DIAGNOSIS CODE #2 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H142.1	DIAGNOSIS CODE #3 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H142.2	DIAGNOSIS CODE #3 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H142.3	DIAGNOSIS CODE #3 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H142.4	DIAGNOSIS CODE #3 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H142.5	DIAGNOSIS CODE #3 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H142.6	DIAGNOSIS CODE #3 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H142.7	DIAGNOSIS CODE #3 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H142.9	DIAGNOSIS CODE #3 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H143.1	DIAGNOSIS CODE #4 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H143.2	DIAGNOSIS CODE #4 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H143.3	DIAGNOSIS CODE #4 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H143.4	DIAGNOSIS CODE #4 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H143.5	DIAGNOSIS CODE #4 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H143.6	DIAGNOSIS CODE #4 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H143.7	DIAGNOSIS CODE #4 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H143.9	DIAGNOSIS CODE #4 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H144.1	DIAGNOSIS CODE #5 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H144.2	DIAGNOSIS CODE #5 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H144.3	DIAGNOSIS CODE #5 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H144.4	DIAGNOSIS CODE #5 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H144.5	DIAGNOSIS CODE #5 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H144.6	DIAGNOSIS CODE #5 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H144.7	DIAGNOSIS CODE #5 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H144.9	DIAGNOSIS CODE #5 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H145.1	DIAGNOSIS CODE #6 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H145.2	DIAGNOSIS CODE #6 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H145.3	DIAGNOSIS CODE #6 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H145.4	DIAGNOSIS CODE #6 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H145.5	DIAGNOSIS CODE #6 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H145.6	DIAGNOSIS CODE #6 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H145.7	DIAGNOSIS CODE #6 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H145.9	DIAGNOSIS CODE #6 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H146.1	DIAGNOSIS CODE #7 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H146.2	DIAGNOSIS CODE #7 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H146.3	DIAGNOSIS CODE #7 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H146.4	DIAGNOSIS CODE #7 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H146.5	DIAGNOSIS CODE #7 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H146.6	DIAGNOSIS CODE #7 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H146.7	DIAGNOSIS CODE #7 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H146.9	DIAGNOSIS CODE #7 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H147.1	DIAGNOSIS CODE #8 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H147.2	DIAGNOSIS CODE #8 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H147.3	DIAGNOSIS CODE #8 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H147.4	DIAGNOSIS CODE #8 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H147.5	DIAGNOSIS CODE #8 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H147.6	DIAGNOSIS CODE #8 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H147.7	DIAGNOSIS CODE #8 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H147.9	DIAGNOSIS CODE #8 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H148.1	DIAGNOSIS CODE #9 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H148.2	DIAGNOSIS CODE #9 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H148.3	DIAGNOSIS CODE #9 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H148.4	DIAGNOSIS CODE #9 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H148.5	DIAGNOSIS CODE #9 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H148.6	DIAGNOSIS CODE #9 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H148.7	DIAGNOSIS CODE #9 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H148.9	DIAGNOSIS CODE #9 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H149.1	ADMITTING DIAGNOSIS CODE NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H149.2	ADMITTING DIAGNOSIS CODE NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H149.3	ADMITTING DIAGNOSIS CODE NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H149.4	ADMITTING DIAGNOSIS CODE NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H149.5	ADMITTING DIAGNOSIS CODE REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H149.6	ADMITTING DIAGNOSIS CODE REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H149.7	ADMITTING DIAGNOSIS CODE REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H149.9	ADMITTING DIAGNOSIS CODE REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H150.1	EMERGENCY DIAGNOSIS CODE NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H150.2	EMERGENCY DIAGNOSIS CODE NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H150.3	EMERGENCY DIAGNOSIS CODE NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H150.4	EMERGENCY DIAGNOSIS CODE NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
H150.5	EMERGENCY DIAGNOSIS CODE REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H150.6	EMERGENCY DIAGNOSIS CODE REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H150.7	EMERGENCY DIAGNOSIS CODE REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H150.9	EMERGENCY DIAGNOSIS CODE REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H154.1	ICD9 PROCEDURE CODE #1 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
H154.2	ICD9 PROCEDURE CODE #1 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H154.3	ICD9 PROCEDURE CODE #1 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
H154.4	ICD9 PROCEDURE CODE #1 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H154.5	ICD9 PROCEDURE CODE #1 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H154.6	ICD9 PROCEDURE CODE #1 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H154.7	ICD9 PROCEDURE CODE #1 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H154.9	ICD9 PROCEDURE CODE #1 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H155.1	ICD9 PROCEDURE CODE #2 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
H155.2	ICD9 PROCEDURE CODE #2 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H155.3	ICD9 PROCEDURE CODE #2 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H155.4	ICD9 PROCEDURE CODE #2 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H155.5	ICD9 PROCEDURE CODE #2 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H155.6	ICD9 PROCEDURE CODE #2 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H155.7	ICD9 PROCEDURE CODE #2 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H155.9	ICD9 PROCEDURE CODE #2 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H156.1	ICD9 PROCEDURE CODE #3 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
H156.2	ICD9 PROCEDURE CODE #3 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H156.3	ICD9 PROCEDURE CODE #3 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
H156.4	ICD9 PROCEDURE CODE #3 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H156.5	ICD9 PROCEDURE CODE #3 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H156.6	ICD9 PROCEDURE CODE #3 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H156.7	ICD9 PROCEDURE CODE #3 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H156.9	ICD9 PROCEDURE CODE #3 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H157.1	ICD9 PROCEDURE CODE #4 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H157.2	ICD9 PROCEDURE CODE #4 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H157.3	ICD9 PROCEDURE CODE #4 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
H157.4	ICD9 PROCEDURE CODE #4 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H157.5	ICD9 PROCEDURE CODE #4 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H157.6	ICD9 PROCEDURE CODE #4 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H157.7	ICD9 PROCEDURE CODE #4 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H157.9	ICD9 PROCEDURE CODE #4 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H158.1	ICD9 PROCEDURE CODE #5 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
H158.2	ICD9 PROCEDURE CODE #5 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H158.3	ICD9 PROCEDURE CODE #5 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
H158.4	ICD9 PROCEDURE CODE #5 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H158.5	ICD9 PROCEDURE CODE #5 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H158.6	ICD9 PROCEDURE CODE #5 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H158.7	ICD9 PROCEDURE CODE #5 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H158.9	ICD9 PROCEDURE CODE #5 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H159.1	ICD9 PROCEDURE CODE #6 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
H159.2	ICD9 PROCEDURE CODE #6 NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
H159.3	ICD9 PROCEDURE CODE #6 NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
H159.4	ICD9 PROCEDURE CODE #6 NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
H159.5	ICD9 PROCEDURE CODE #6 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H159.6	ICD9 PROCEDURE CODE #6 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H159.7	ICD9 PROCEDURE CODE #6 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
H159.9	ICD9 PROCEDURE CODE #6 REQUIRES P/A, P/A MISMATCH	N54	Claim information is inconsistent with pre-certified/authorized services.		
H160.1	ICD9 PROCEDURE CODE #1 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H160.2	ICD9 PROCEDURE CODE #1 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H160.3	ICD9 PROCEDURE CODE #1 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		
H161.1	ICD9 PROCEDURE CODE #2 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H161.2	ICD9 PROCEDURE CODE #2 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H161.3	ICD9 PROCEDURE CODE #2 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H162.1	ICD9 PROCEDURE CODE #3 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H162.2	ICD9 PROCEDURE CODE #3 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H162.3	ICD9 PROCEDURE CODE #3 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		
H163.1	ICD9 PROCEDURE CODE #4 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H163.2	ICD9 PROCEDURE CODE #4 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H163.3	ICD9 PROCEDURE CODE #4 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		
H164.1	ICD9 PROCEDURE CODE #5 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H164.2	ICD9 PROCEDURE CODE #5 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H164.3	ICD9 PROCEDURE CODE #5 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		
H165.1	ICD9 PROCEDURE CODE #6 INVALID FOR RECIP AGE & GENDER	6 7	The procedure/revenue code is inconsistent with the patient's age. The procedure/revenue code is inconsistent with the patient's gender.		
H165.2	ICD9 PROCEDURE CODE #6 INVALID FOR RECIPIENT AGE	6	The procedure/revenue code is inconsistent with the patient's age.		
H165.3	ICD9 PROCEDURE CODE #6 INVALID FOR RECIPIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender.		
H166.2	TRAUMA DIAGNOSIS CODE CODE IS INVALID	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H167.1	HEALTH PLAN PAID AMOUNT FIELD IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks code whenever appropriate.		
H168.1	OCCURRENCE DATE #1 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H169.1	OCCURRENCE DATE #2 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H170.1	OCCURRENCE DATE #3 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H171.1	OCCURRENCE DATE #4 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H172.1	OCCURRENCE DATE #5 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H173.1	OCCURRENCE DATE #6 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H174.1	OCCURRENCE DATE #7 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H175.1	OCCURRENCE DATE #8 VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			M45	Incomplete/invalid occurrence codes and dates.
H176.1	MATERNITY CLAIM INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H176.2	MATERNITY CLAIM INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H176.3	MATERNITY CLAIM INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H177.1	NEWBORN CLAIM INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
H177.2	NEWBORN CLAIM INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
H177.3	NEWBORN CLAIM INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
H178.1	NON-FFS REIMBURSMENT TYPE; PROVIDER NOT AUTHORIZED TO BILL FOR SVC	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
H178.2	NON-FFS REIMBURSMENT TYPE; PROVIDER NO RATE FOUND	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
H179.1	RECIPIENT ENROLLED IN PLAN FOR ENTIRE SERVICE DATE SPAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
H179.2	RECIPIENT ENROLLED IN PLAN FOR SOME OF SERVICE DATE SPAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
H180.1	OUT OF STATE (NON-IHS) PROVIDER NOT AUTHORIZED TO BILL FOR SVC	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H180.2	OUT OF STATE (NON-IHS) PROVIDER NO RATE FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H181.1	NON-CAT RECIPIENT; IHS PROVIDER NOT AUTHORIZED TO BILL FOR SVC	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H181.2	NON-CAT RECIPIENT; IHS PROVIDER NO RATE FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H184.1	DIAG/PROC INDICATES STERILIZATION CLAIM; ATTACHMENTS REQUIRED			N28	Consent form requirements not fulfilled.
H185.1	VALUE CODE INCONSISTENT WITH BILL TYPE CLAIM INCONSISTENCY			M49	Incomplete/invalid value code(s) and/or amount(s).
H185.2	VALUE CODE INCONSISTENT WITH BILL TYPE POSSIBLE CLAIM INCONSISTENCY			M49	Incomplete/invalid value code(s) and/or amount(s).
H186.1	VALUE CODE INDICATES MEDICARE PART B; CLAIM INCONSISTENCY			M49	Incomplete/invalid value code(s) and/or amount(s).
H186.2	VALUE CODE INDICATES MEDICARE PART B; POSSIBLE CLAIM INCONSISTENCY			M49	Incomplete/invalid value code(s) and/or amount(s).
H188.1	INVALID DISCHARGE DATA ON FINAL BILL; CLAIM INCONSISTENCY			N50	Discharge information missing/incomplete/incorrect/invalid.
H188.2	INVALID DISCHARGE DATA ON FINAL BILL; POSSIBLE CLAIM INCONSISTENCY			N50	Discharge information missing/incomplete/incorrect/invalid.
H189.1	RECIPIENT HAS MEDICARE; MEDICARE MUST BE INDICATED, IS MISSING			MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
H189.2	RECIPIENT HAS MEDICARE; MEDICARE STARTS BETWEEN SERVICE DATES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
H190.1	NEWBORN ADMIT TYPE; INVALID ADMIT SOURCE CLAIM INCONSISTENCY			MA41	Incomplete/invalid type of admission.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H190.2	NEWBORN ADMIT TYPE; INVALID ADMIT SOURCE POSSIBLE CLAIM INCONSISTENCY			MA41	Incomplete/invalid type of admission.
H192.1	RECIPIENT HAS OTHER INSURANCE; TPL DATA MUST BE INDICATED, IS MISSING	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
H192.2	RECIPIENT HAS OTHER INSURANCE; TPL DATA STARTS BETWEEN SERVICE DATES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
H194.1	OCCUR CODE INDICATES MEDICARE EXHAUSTED CLAIM MUST BE SPLIT	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		
H198.1	INPATIENT/LTC CLAIM W/O ACCOMMODATION CD CLAIM INCONSISTENCY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Incomplete/invalid revenue code(s).
H198.2	INPATIENT/LTC CLAIM W/O ACCOMMODATION CD POSSIBLE CLAIM INCONSISTENCY			M50	Incomplete/invalid revenue code(s).
H199.1	CLAIM RECEIVED PAST 9 MONTH LIMIT	29	The time limit for filing has expired.		
H199.2	CLAIM RECEIVED PAST 12 MONTH LIMIT, DENY	29	The time limit for filing has expired.		
H199.4	CLAIM RECEIVED PAST 6 MONTH LIMIT	29	The time limit for filing has expired.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H200.1	SERVICE PROVIDER STATUS NOT ACTIVE; NOT AUTHORIZED TO BILL FOR SVC	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H200.2	SERVICE PROVIDER STATUS NOT ACTIVE; NO RATE FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H201.1	BILLING PROVIDER STATUS NOT ACTIVE; NOT AUTHORIZED TO BILL FOR SVC	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H201.2	BILLING PROVIDER STATUS NOT ACTIVE; NO RATE FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H202.1	PROVIDER HAS BILL TYPE RESTRICTION; CLAIM DISALLOWED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H204.1	DUPLICATE CHECK FAILED; NEAR DUPLICATE CLAIM	18	Duplicate claim/service.		
H204.2	DUPLICATE CHECK FAILED; DUPLICATE CLAIM	18	Duplicate claim/service.		
H204.3	DUPLICATE CHECK FAILED; DATE CROSSOVER DUPLICATE CLAIM	18	Duplicate claim/service.		
H204.4	DUPLICATE CHECK FAILED; NEAR DUP / ASSISTANT SURGERY	18	Duplicate claim/service.		
H204.5	DUPLICATE CHECK FAILED; DUPLICATE MCO CLAIM ON FILE	18	Duplicate claim/service.		
H204.6	DUPLICATE CHECK FAILED; MEDICARE CROSSOVER DUPLICATE	18	Duplicate claim/service.		
H205.1	INPATIENT CLAIM OVERLAPS OUTPATIENT CLM; SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	MA33	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
H206.1	UB92 DIALYSIS CLM OVERLAPS HCFA 1500 LAB SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	MA33	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H210.1	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT ENROLLED WITH DHS	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
H210.2	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT IS SMI	96	Non-covered charge(s).		
H210.3	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; SERVICE NOT INPATIENT PSYCH	96	Non-covered charge(s).		
H210.4	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT AGE IS INAPPROPRIATE	6	The procedure code is inconsistent with the patient's age.		
H210.5	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; INAPPROPRIATE CONTRACT TYPE	96	Non-covered charge(s).		
H210.6	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; SERVICES NON EMERGENCY	96	Non-covered charge(s).		
H210.7	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; NON IHS PROV; RCP ENRLD W/RBHA	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan..		
H212.2	MEDICARE LIFETIME RESERVE DAYS FIELD IS NOT NUMERIC	67	Lifetime reserve days. (Handled in QTY, QTY01=LA)		
H212.3	MEDICARE LIFETIME RESERVE DAYS FIELD IS ZERO	67	Lifetime reserve days. (Handled in QTY, QTY01=LA)		
H212.4	MEDICARE LIFETIME RESERVE DAYS FIELD IS NEGATIVE	67	Lifetime reserve days. (Handled in QTY, QTY01=LA)		
H213.2	MEDICARE COINSURANCE DAYS FIELD IS NOT NUMERIC			MA04	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.
H213.3	MEDICARE COINSURANCE DAYS FIELD IS ZERO			MA04	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.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H213.4	MEDICARE COINSURANCE DAYS FIELD IS NEGATIVE			MA04	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.
H214.1	PODIATRIST W/INVALID REFERRING PROVIDER; INVALID COMBINATION OF CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
H216.1	RECIPIENT NOT ELIG/ENRL FOR ENTIRE DOS; INVALID ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H216.2	RECIPIENT NOT ELIG/ENRL FOR ENTIRE DOS; INVALID ENROLLMENT	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H217.1	INPATIENT CLAIM OVERLAPS LAB/RADIOLOGY; SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
H218.1	SERVICE NOT COVERED FOR ESP RECIPIENT; MUST BE EMERGENCY/PREGNANCY/PA	96	Non-covered charge(s).		
H218.2	SERVICE NOT COVERED FOR ESP RECIPIENT; ACTIVITY NOT IN SERVICE PACKGE	96	Non-covered charge(s).		
H218.3	SERVICE NOT COVERED FOR ESP RECIPIENT; EXTENDED SERVICES CONFLICT	96	Non-covered charge(s).		
H218.4	SERVICE NOT COVERED FOR ESP RECIPIENT; MUST BE EMERGENCY OR PA	96	Non-covered charge(s).		
H219.1	ADMIT DATE VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			MA40	Incomplete/invalid admission date.
H220.1	PRIOR AUTHORIZATION IS DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H220.3	PRIOR AUTHORIZATION MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H221.1	PROVIDER TAX ID FIELD IS MISSING			N31	Prescribing/referring/attending practitioner license number is absent/incorrect/incomplete.
H221.2	PROVIDER TAX ID FIELD IS INVALID FORMAT			N31	Prescribing/referring/attending practitioner license number is absent/incorrect/incomplete.
H221.3	PROVIDER TAX ID FIELD IS NOT ON FILE			N31	Prescribing/referring/attending practitioner license number is absent/incorrect/incomplete.
H226.1	DIALYSIS REQUIRES PA OR REVIEW; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H226.2	DIALYSIS REQUIRES PA OR REVIEW; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H226.3	DIALYSIS REQUIRES PA OR REVIEW; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H226.4	DIALYSIS REQUIRES PA OR REVIEW; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H226.5	DIALYSIS REQUIRES PA OR REVIEW; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H226.6	DIALYSIS REQUIRES PA OR REVIEW; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H227.1	MDC DEDUCTIBLE+COINSURANCE VS BILLED AMT AMOUNT SHOULD NOT BE GREATER			MA04	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.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H228.1	THERAPY REQUIRES PRIOR AUTHORIZATION; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H228.2	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H228.3	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H228.4	THERAPY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H228.5	THERAPY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H228.6	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H229.1	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H229.2	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H229.3	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H229.4	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H229.5	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H229.6	NON-EMG HOSPITAL ADMISSION REQUIRES P/A; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H230.1	OUT-OF-STATE LONG STAY REQUIRES P/A; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H230.2	OUT-OF-STATE LONG STAY REQUIRES P/A; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H230.3	OUT-OF-STATE LONG STAY REQUIRES P/A; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H230.4	OUT-OF-STATE LONG STAY REQUIRES P/A; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H230.5	OUT-OF-STATE LONG STAY REQUIRES P/A; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H230.6	OUT-OF-STATE LONG STAY REQUIRES P/A; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H232.1	CLAIM HAS MORE THAN ONE BUNDLED SERVICE; COMPONENT OF GROUP PREV BILLED	97	Payment is included in the allowance for another service/procedure.		
H232.2	CLAIM HAS MORE THAN ONE BUNDLED SERVICE; COMPONENT OF GROUP, OVERLAPPED	97	Payment is included in the allowance for another service/procedure.		
H232.3	CLAIM HAS MORE THAN ONE BUNDLED SERVICE; GROUP W/ COMPONENT PREV PAID	97	Payment is included in the allowance for another service/procedure.		
H232.4	CLAIM HAS MORE THAN ONE BUNDLED SERVICE; GROUP OVERLAPPED W/ COMPONENT	97	Payment is included in the allowance for another service/procedure.		
H234.1	BIRTHING CENTER CLAIM/BILL TYPE NOT 84X; CLAIM INCONSISTENCY	5	The procedure code/bill type is inconsistent with the place of service.		
H234.2	BIRTHING CENTER CLAIM/BILL TYPE NOT 84X; POSSIBLE CLAIM INCONSISTENCY	5	The procedure code/bill type is inconsistent with the place of service.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H235.1	HOSPICE PROVIDER TYPE/BILL TYPE INVALID; NOT AUTHORIZED TO BILL FOR SVC	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type may not bill this service
H235.2	HOSPICE PROVIDER TYPE/BILL TYPE INVALID; NO RATE FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type may not bill this service
H238.2	PRIMARY DIAGNOSIS INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H239.2	ICD9 PROCEDURE #1 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H240.2	ICD9 PROCEDURE #2 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H241.2	ICD9 PROCEDURE #3 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H242.2	ICD9 PROCEDURE #4 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H243.2	ICD9 PROCEDURE #5 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H244.2	ICD9 PROCEDURE #6 INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H246.1	ICD9 PROCEDURE DATE #1 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H246.2	ICD9 PROCEDURE DATE #1 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H247.1	ICD9 PROCEDURE DATE #2 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H247.2	ICD9 PROCEDURE DATE #2 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H248.1	ICD9 PROCEDURE DATE #3 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H248.2	ICD9 PROCEDURE DATE #3 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H249.1	ICD9 PROCEDURE DATE #4 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H249.2	ICD9 PROCEDURE DATE #4 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H250.1	ICD9 PROCEDURE DATE #5 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H250.2	ICD9 PROCEDURE DATE #5 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H251.1	ICD9 PROCEDURE DATE #6 IS NOT WITHIN SERVICE DATES			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
H251.2	ICD9 PROCEDURE DATE #6 REMOVED; RECIP NOT ELIGIBLE	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H252.1	NON-HOSPITAL UB92 FOR ESP RECIPIENT PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H252.2	NON-HOSPITAL UB92 FOR ESP RECIPIENT P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H252.3	NON-HOSPITAL UB92 FOR ESP RECIPIENT P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H252.4	NON-HOSPITAL UB92 FOR ESP RECIPIENT SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H252.5	NON-HOSPITAL UB92 FOR ESP RECIPIENT SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H252.6	NON-HOSPITAL UB92 FOR ESP RECIPIENT P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H253.1	CATEGORY OF SERVICE NOT FOUND FOR PROVIDER	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H253.2	CATEGORY OF SERVICE NOT FOUND FOR MEDICAL SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H253.3	CATEGORY OF SERVICE PROVIDER IS NOT AUTHORIZED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H253.4	CATEGORY OF SERVICE NOT VALID FOR BILL TYPE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
H254.1	RECIPIENT IS QMB ONLY; INVALID ELIGIBILITY	31	Claim denied as patient cannot be identified as our insured.		
H254.2	RECIPIENT IS QMB ONLY; INVALID ENROLLMENT	31	Claim denied as patient cannot be identified as our insured.		
H257.1	RECIPIENT IS KIDS CARE DIRECT SERVICES; INVALID ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible period of coverage.		
H257.2	RECIPIENT IS KIDS CARE DIRECT SERVICES; INVALID ENROLLMENT	31	Claim denied as patient cannot be identified as our insured.		
H258.1	INPATIENT BHS SERVICE REQUIRES P/A; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H258.2	INPATIENT BHS SERVICE REQUIRES P/A; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
H258.3	INPATIENT BHS SERVICE REQUIRES P/A; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
H258.4	INPATIENT BHS SERVICE REQUIRES P/A; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H258.5	INPATIENT BHS SERVICE REQUIRES P/A; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H258.6	INPATIENT BHS SERVICE REQUIRES P/A; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
H259.1	PLZ CONTACT TRBHA 4 POSSIBLE SUBVENTION POSSIBLE SUBVENTION	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
L001.1	PROCEDURE CODE FIELD IS MISSING			M67	Incomplete/invalid other procedure code(s) and/or date(s).
L001.2	PROCEDURE CODE FIELD IS INVALID FORMAT			M67	Incomplete/invalid other procedure code(s) and/or date(s).
L001.3	PROCEDURE CODE FIELD IS NOT ON FILE			M67	Incomplete/invalid other procedure code(s) and/or date(s).
L002.1	REVENUE CODE FIELD IS MISSING			M50	Incomplete/invalid revenue code(s).
L002.2	REVENUE CODE FIELD IS INVALID FORMAT			M50	Incomplete/invalid revenue code(s).
L002.3	REVENUE CODE FIELD IS NOT ON FILE			M50	Incomplete/invalid revenue code(s).
L003.1	PHARMACY ITEM FIELD IS MISSING			M119	National Drug Code (NDC) needed.
L003.2	PHARMACY ITEM FIELD IS INVALID FORMAT			M119	National Drug Code (NDC) needed.
L003.3	PHARMACY ITEM FIELD IS NOT ON FILE			M119	National Drug Code (NDC) needed.
L004.1	SERVICE BEGIN DATE IS MISSING			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L004.2	SERVICE BEGIN DATE HAS INVALID FORMAT			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L004.3	SERVICE BEGIN DATE IS NOT POSSIBLE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L004.4	SERVICE BEGIN DATE IS IN THE FUTURE			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L005.1	SERVICE END DATE IS MISSING			M59	Incomplete/invalid “to” date(s) of service.
L005.2	SERVICE END DATE HAS INVALID FORMAT			M59	Incomplete/invalid “to” date(s) of service.
L005.3	SERVICE END DATE IS NOT POSSIBLE			M59	Incomplete/invalid “to” date(s) of service.
L005.4	SERVICE END DATE IS IN THE FUTURE			M59	Incomplete/invalid “to” date(s) of service.
L006.1	DISPENSE DATE DATE IS MISSING			N57	Missing/incomplete/invalid prescribing/dispensed date.
L006.2	DISPENSE DATE DATE HAS INVALID FORMAT			N57	Missing/incomplete/invalid prescribing/dispensed date.
L006.3	DISPENSE DATE DATE IS NOT POSSIBLE			N57	Missing/incomplete/invalid prescribing/dispensed date.
L006.4	DISPENSE DATE DATE IS IN THE FUTURE			N57	Missing/incomplete/invalid prescribing/dispensed date.
L007.1	PRESCRIBE DATE DATE IS MISSING			N57	Missing/incomplete/invalid prescribing/dispensed date.
L007.2	PRESCRIBE DATE DATE HAS INVALID FORMAT			N57	Missing/incomplete/invalid prescribing/dispensed date.
L007.3	PRESCRIBE DATE DATE IS NOT POSSIBLE			N57	Missing/incomplete/invalid prescribing/dispensed date.
L007.4	PRESCRIBE DATE DATE IS IN THE FUTURE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N57	Missing/incomplete/invalid prescribing/dispensed date.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L008.1	SERVICE BEGIN VS SERVICE END DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L009.1	10/01/82 VS SERVICE BEGIN DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L010.1	SERVICE END DATE VS CLAIM RECEIPT DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L011.1	PRESCRIBE DATE VS DISPENSE DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L012.1	10/01/82 VS DISPENSE DATE DATE #2 IS PRIOR TO DATE #1			MA06	Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
L013.1	CLAIM SERVICE NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L013.2	CLAIM SERVICE NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
L013.3	CLAIM SERVICE NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
L013.4	CLAIM SERVICE NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
L013.5	CLAIM SERVICE REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L013.6	CLAIM SERVICE REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L013.7	CLAIM SERVICE REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L013.9	CLAIM SERVICE REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L016.1	CATEGORY OF SERVICE NOT FOUND FOR PROVIDER	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L016.2	CATEGORY OF SERVICE NOT FOUND FOR MEDICAL SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L016.3	CATEGORY OF SERVICE PROVIDER IS NOT AUTHORIZED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L017.1	PLACE OF SERVICE CODE IS MISSING			N38	Place of service missing.
L018.1	HCPCS PROCEDURE/PLACE OF SERVICE INVALID COMBINATION OF CODES	5	The procedure code/bill type is inconsistent with the place of service.		
L019.1	DIAGNOSIS CODE #1 HAS MISSING REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L019.2	DIAGNOSIS CODE #1 HAS INVALID REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L019.3	DIAGNOSIS CODE #1 IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L019.4	DIAGNOSIS CODE #1 HAS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L019.5	DIAGNOSIS CODE #1 IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L020.1	DIAGNOSIS CODE #2 HAS MISSING REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L020.2	DIAGNOSIS CODE #2 HAS INVALID REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L020.3	DIAGNOSIS CODE #2 IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L020.4	DIAGNOSIS CODE #2 HAS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L020.5	DIAGNOSIS CODE #2 IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L021.1	DIAGNOSIS CODE #3 HAS MISSING REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L021.2	DIAGNOSIS CODE #3 HAS INVALID REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L021.3	DIAGNOSIS CODE #3 IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L021.4	DIAGNOSIS CODE #3 HAS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid..		
L021.5	DIAGNOSIS CODE #3 IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L022.1	DIAGNOSIS CODE #4 HAS MISSING REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid..		
L022.2	DIAGNOSIS CODE #4 HAS INVALID REFERENCE CODE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L022.3	DIAGNOSIS CODE #4 IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L022.4	DIAGNOSIS CODE #4 HAS INVALID FORMAT	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L022.5	DIAGNOSIS CODE #4 IS NOT ON FILE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L023.1	DIAGNOSIS CODE #1 INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
L023.2	DIAGNOSIS CODE #1 INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
L023.3	DIAGNOSIS CODE #1 INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
L024.1	DIAGNOSIS CODE #2 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
L024.2	DIAGNOSIS CODE #2 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
L024.3	DIAGNOSIS CODE #2 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L025.1	DIAGNOSIS CODE #3 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
L025.2	DIAGNOSIS CODE #3 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
L025.3	DIAGNOSIS CODE #3 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
L026.1	DIAGNOSIS CODE #4 IS INVALID FOR RECIP AGE & GENDER	9 10	The diagnosis is inconsistent with the patient's age. The diagnosis is inconsistent with the patient's gender.		
L026.2	DIAGNOSIS CODE #4 IS INVALID FOR RECIPIENT AGE	9	The diagnosis is inconsistent with the patient's age.		
L026.3	DIAGNOSIS CODE #4 IS INVALID FOR RECIPIENT GENDER	10	The diagnosis is inconsistent with the patient's gender.		
L028.1	DIAGNOSIS REFERENCE #1 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L028.2	DIAGNOSIS REFERENCE #1 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L028.3	DIAGNOSIS REFERENCE #1 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L028.4	DIAGNOSIS REFERENCE #1 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L028.5	DIAGNOSIS REFERENCE #1 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L028.6	DIAGNOSIS REFERENCE #1 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L028.7	DIAGNOSIS REFERENCE #1 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L028.9	DIAGNOSIS REFERENCE #1 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L029.1	DIAGNOSIS REFERENCE #2 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L029.2	DIAGNOSIS REFERENCE #2 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L029.3	DIAGNOSIS REFERENCE #2 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L029.4	DIAGNOSIS REFERENCE #2 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L029.5	DIAGNOSIS REFERENCE #2 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L029.6	DIAGNOSIS REFERENCE #2 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L029.7	DIAGNOSIS REFERENCE #2 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L029.9	DIAGNOSIS REFERENCE #2 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L030.1	DIAGNOSIS REFERENCE #3 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L030.2	DIAGNOSIS REFERENCE #3 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L030.3	DIAGNOSIS REFERENCE #3 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L030.4	DIAGNOSIS REFERENCE #3 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L030.5	DIAGNOSIS REFERENCE #3 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L030.6	DIAGNOSIS REFERENCE #3 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L070.1	CATEGORY OF SERVICE/CONTRACT TYPE; CLAIM INCONSISTENCY	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L070.2	CATEGORY OF SERVICE/CONTRACT TYPE; POSSIBLE CLAIM INCONSISTENCY	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L073.1	REVENUE CODE/BILL TYPE COMBINATION NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L073.2	REVENUE CODE/BILL TYPE COMBINATION NOT COVERED FOR SERVICE DATES	96	Non-covered charge(s).		
L073.3	REVENUE CODE/BILL TYPE COMBINATION NOT COVERED FOR CONTRACT TYPE	96	Non-covered charge(s).		
L073.4	REVENUE CODE/BILL TYPE COMBINATION NOT COVERED EXCEPT FOR PREG	96	Non-covered charge(s).		
L073.5	REVENUE CODE/BILL TYPE COMBINATION REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L073.6	REVENUE CODE/BILL TYPE COMBINATION REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L073.7	REVENUE CODE/BILL TYPE COMBINATION REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L073.9	REVENUE CODE/BILL TYPE COMBINATION REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L075.1	CESAREAN PROCEDURE BILLED; NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L075.2	CESAREAN PROCEDURE BILLED; NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L075.3	CESAREAN PROCEDURE BILLED; COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L076.1	CLAIM RECEIVED PAST 9 MONTH LIMIT	29	The time limit for filing has expired.		
L076.2	CLAIM RECEIVED PAST 12 MONTH LIMIT, DENY	29	The time limit for filing has expired.		
L076.4	CLAIM RECEIVED PAST 6 MONTH LIMIT	29	The time limit for filing has expired.		
L080.1	QMB RECIPIENT; ALLOW NON-COVERED SERVICE	96	Non-covered charge(s).		
L081.1	DUPLICATE CHECK FAILED; NEAR DUPLICATE CLAIM	18	Duplicate claim/service.		
L081.2	DUPLICATE CHECK FAILED; DUPLICATE CLAIM	18	Duplicate claim/service.		
L081.3	DUPLICATE CHECK FAILED; DATE CROSSOVER DUPLICATE CLAIM	18	Duplicate claim/service.		
L081.4	DUPLICATE CHECK FAILED; NEAR DUP / ASSISTANT SURGERY	18	Duplicate claim/service.		
L081.5	DUPLICATE CHECK FAILED; DUPLICATE MCO CLAIM ON FILE	18	Duplicate claim/service.		
L081.6	DUPLICATE CHECK FAILED; MEDICARE CROSSOVER DUPLICATE	18	Duplicate claim/service.		
L082.1	DUPLICATE CHECK FAILED; NEAR DUPLICATE CLAIM	18	Duplicate claim/service.		
L082.2	DUPLICATE CHECK FAILED; DUPLICATE CLAIM	18	Duplicate claim/service.		
L082.3	DUPLICATE CHECK FAILED; DATE CROSSOVER DUPLICATE CLAIM	18	Duplicate claim/service.		
L082.4	DUPLICATE CHECK FAILED; NEAR DUP / ASSISTANT SURGERY	18	Duplicate claim/service.		
L082.5	DUPLICATE CHECK FAILED; DUPLICATE MCO CLAIM ON FILE	18	Duplicate claim/service.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L083.1	PRIOR AUTHORIZATION IS DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L083.3	PRIOR AUTHORIZATION MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L084.1	DME SERVICE REQUIRES PRIOR AUTHORIZATION PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L084.2	DME SERVICE REQUIRES PRIOR AUTHORIZATION P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L084.3	DME SERVICE REQUIRES PRIOR AUTHORIZATION P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L084.4	DME SERVICE REQUIRES PRIOR AUTHORIZATION SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L084.5	DME SERVICE REQUIRES PRIOR AUTHORIZATION SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L084.6	DME SERVICE REQUIRES PRIOR AUTHORIZATION P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L085.1	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L085.2	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L085.3	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L085.4	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L085.5	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L085.6	SUPPLIES OVER $50 REQUIRE PRIOR AUTH; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L086.1	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L086.2	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L086.3	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L086.4	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L086.5	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L086.6	HOME HEALTH SERVICE REQUIRES PRIOR AUTH; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L087.1	DRUG REQUIRES PRIOR AUTHORIZATION; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L087.2	DRUG REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L087.3	DRUG REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L087.4	DRUG REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L087.5	DRUG REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L087.6	DRUG REQUIRES PRIOR AUTHORIZATION; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L088.1	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L088.2	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L088.3	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L088.4	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L088.5	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L088.6	NON-EMG TRANSPORT REQUIRES PRIOR AUTH; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L090.1	HOSPITAL VISIT WITHIN SURGERY FOLLOW-UP; SVC EXCLUDED BY PREV CLAIM SVC	97	Payment is included in the allowance for another service/procedure.		
L091.1	PODIATRY REQUIRES PRIOR AUTHORIZATION; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L091.2	PODIATRY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L091.3	PODIATRY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L091.4	PODIATRY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L091.5	PODIATRY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L091.6	PODIATRY REQUIRES PRIOR AUTHORIZATION; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L093.1	LAB CLAIM OVERLAPS UB92 DIALYSIS SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
L094.1	OVERLAPPING LAB SERVICES BILLED SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
L095.1	ANESTHESIA CONFLICT, PROC VS MODIFIER; INVALID COMBINATION OF CODES			M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L096.1	OUT OF STATE (NON-IHS) PROVIDER NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L098.1	CRNA/SURGERY WITHOUT ANESTHESIA MODIFER; INVALID COMBINATION OF CODES			M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L099.1	RECIPIENT NOT ELIG/ENRL FOR ENTIRE DOS; INVALID ELIGIBILITY	31	Claim denied as patient cannot be identified as our insured.		
L099.2	RECIPIENT NOT ELIG/ENRL FOR ENTIRE DOS; INVALID ENROLLMENT	31	Claim denied as patient cannot be identified as our insured.		
L100.1	LAB/RADIOLOGY CLAIM OVERLAPS INPATIENT; SVC EXCLUDED BY PREV CLAIM SVC	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
L101.1	SERVICE NOT COVERED FOR ESP RECIPIENT; MUST BE EMERGENCY/PREGNANCY/PA	96	Non-covered charge(s).		
L101.2	SERVICE NOT COVERED FOR ESP RECIPIENT; ACTIVITY NOT IN SERVICE PACKGE	96	Non-covered charge(s).		
L101.3	SERVICE NOT COVERED FOR ESP RECIPIENT; EXTENDED SERVICES CONFLICT	96	Non-covered charge(s).		
L101.4	SERVICE NOT COVERED FOR ESP RECIPIENT; MUST BE EMERGENCY OR PA	96	Non-covered charge(s).		
L103.1	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT ENROLLED WITH DHS	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
L103.2	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT IS SMI	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
L103.3	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; SERVICE NOT INPATIENT PSYCH	96	Non-covered charge(s).		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L103.4	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; RECIPIENT AGE IS INAPPROPRIATE	6	The procedure code is inconsistent with the patient's age.		
L103.5	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; INAPPROPRIATE CONTRACT TYPE	96	Non-covered charge(s).		
L103.6	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; SERVICES NON EMERGENCY	40	Charges do not meet qualifications for emergent/urgent care.		
L103.7	NOT ENTITLED TO BEHAVIORAL HEALTH SRV; NON IHS PROV; RCP ENRLD W/RBHA	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
L106.1	THERAPY REQUIRES PRIOR AUTHORIZATION; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L106.2	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L106.3	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L106.4	THERAPY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L106.5	THERAPY REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L106.6	THERAPY REQUIRES PRIOR AUTHORIZATION; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L107.1	DIALYSIS REQUIRES PRIOR AUTHORIZATION; PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L030.7	DIAGNOSIS REFERENCE #3 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L030.9	DIAGNOSIS REFERENCE #3 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L031.1	DIAGNOSIS REFERENCE #4 NOT COVERED BY MED-QUEST	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L031.2	DIAGNOSIS REFERENCE #4 NOT COVERED FOR SERVICE DATES	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L031.3	DIAGNOSIS REFERENCE #4 NOT COVERED FOR CONTRACT TYPE	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L031.4	DIAGNOSIS REFERENCE #4 NOT COVERED EXCEPT FOR PREG	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		
L031.5	DIAGNOSIS REFERENCE #4 REQUIRES P/A, NONE FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L031.6	DIAGNOSIS REFERENCE #4 REQUIRES P/A, P/A DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L031.7	DIAGNOSIS REFERENCE #4 REQUIRES P/A, P/A NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L031.9	DIAGNOSIS REFERENCE #4 REQUIRES P/A, P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L032.1	PROCEDURE CODE IS INVALID FOR RECIP AGE & GENDER	6 7	The procedure code is inconsistent with the patient's age. The procedure code is inconsistent with the patient's gender.		
L032.2	PROCEDURE CODE IS INVALID FOR RECIPIENT AGE	6	The procedure code is inconsistent with the patient's age.		
L032.3	PROCEDURE CODE IS INVALID FOR RECIPIENT GENDER	7	The procedure code is inconsistent with the patient's gender.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L034.1	PHARMACY ITEM IS INVALID FOR RECIP AGE & GENDER	6 7	The procedure code is inconsistent with the patient's age. The procedure code is inconsistent with the patient's gender.		
L034.2	PHARMACY ITEM IS INVALID FOR RECIPIENT AGE	6	The procedure code is inconsistent with the patient's age.		
L034.3	PHARMACY ITEM IS INVALID FOR RECIPIENT GENDER	7	The procedure code is inconsistent with the patient's gender.		
L035.1	REVENUE CODE IS INVALID FOR RECIP AGE & GENDER	6 7	The procedure code is inconsistent with the patient's age. The procedure code is inconsistent with the patient's gender.		
L035.2	REVENUE CODE IS INVALID FOR RECIPIENT AGE	6	The procedure code is inconsistent with the patient's age.		
L035.3	REVENUE CODE IS INVALID FOR RECIPIENT GENDER	7	The procedure code is inconsistent with the patient's gender.		
L036.1	SERVICE BEGIN DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.		
L036.2	SERVICE BEGIN DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		
L037.1	SERVICE END DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.		
L037.2	SERVICE END DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		
L038.1	DISPENSE DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.		
L038.2	DISPENSE DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		
L039.1	PRESCRIBE DATE IS PRIOR TO DATE OF BIRTH	14	The date of birth follows the date of service.		
L039.2	PRESCRIBE DATE IS AFTER DATE OF DEATH	13	The date of death precedes the date of service.		
L040.1	REVENUE CODE/HCPCS PROCEDURE CODE INVALID COMBINATION OF CODES			M50	Incomplete/invalid revenue code(s).

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L041.1	BILLED CHARGES FIELD IS MISSING			M54	Did not complete or enter the correct total charges for services rendered.
L041.2	BILLED CHARGES FIELD IS NOT NUMERIC			M54	Did not complete or enter the correct total charges for services rendered.
L041.3	BILLED CHARGES FIELD IS ZERO			M54	Did not complete or enter the correct total charges for services rendered.
L041.4	BILLED CHARGES FIELD IS NEGATIVE			M54	Did not complete or enter the correct total charges for services rendered.
L043.1	MEDICARE DEDUCTIBLE AMOUNT FIELD IS MISSING			MA04	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.
L043.2	MEDICARE DEDUCTIBLE AMOUNT FIELD IS NOT NUMERIC			MA04	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.
L043.3	MEDICARE DEDUCTIBLE AMOUNT FIELD IS ZERO			MA04	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.
L043.4	MEDICARE DEDUCTIBLE AMOUNT FIELD IS NEGATIVE			MA04	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.
L044.1	MEDICARE COINSURANCE AMOUNT FIELD IS MISSING			MA04	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.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L044.2	MEDICARE COINSURANCE AMOUNT FIELD IS NOT NUMERIC			MA04	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.
L044.3	MEDICARE COINSURANCE AMOUNT FIELD IS ZERO			MA04	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.
L044.4	MEDICARE COINSURANCE AMOUNT FIELD IS NEGATIVE			MA04	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.
L045.1	OTHER COVERAGE AMOUNT FIELD IS MISSING			MA04	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.
L045.2	OTHER COVERAGE AMOUNT FIELD IS NOT NUMERIC			MA04	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.
L045.3	OTHER COVERAGE AMOUNT FIELD IS ZERO			MA04	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.
L045.4	OTHER COVERAGE AMOUNT FIELD IS NEGATIVE			MA04	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.

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L046.1	NON-EMG DENTAL FOR RCPS OVER 20 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L046.2	NON-EMG DENTAL FOR RCPS OVER 20 NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).		
L046.3	NON-EMG DENTAL FOR RCPS OVER 20 COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L047.1	DENTURE COVERAGE NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L047.2	DENTURE COVERAGE NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).		
L047.3	DENTURE COVERAGE COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L048.1	LTC SERVICE BILLED ON UB92 NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L048.2	LTC SERVICE BILLED ON UB92 NO RATE FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L049.1	DISPENSE DATE 1 YEAR PAST PRESCRIBE DATE UNACCEPTABLE W/ MED-QUEST POLICY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L050.1	RECIPIENT ENROLLED IN PLAN FOR ENTIRE SERVICE DATE SPAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
L050.2	RECIPIENT ENROLLED IN PLAN FOR SOME OF SERVICE DATE SPAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
L051.1	MDC DEDUCTIBLE+COINSURANCE VS BILLED AMT AMOUNT SHOULD NOT BE GREATER			MA04	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.

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L052.1	MEDICARE PAID AMOUNT FIELD IS MISSING			MA04	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.
L052.2	MEDICARE PAID AMOUNT FIELD IS NOT NUMERIC			MA04	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.
L052.3	MEDICARE PAID AMOUNT FIELD IS ZERO			MA04	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.
L052.4	MEDICARE PAID AMOUNT FIELD IS NEGATIVE			MA04	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.
L053.1	MEDICARE APPROVED AMOUNT FIELD IS MISSING			MA04	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.
L053.2	MEDICARE APPROVED AMOUNT FIELD IS NOT NUMERIC			MA04	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.
L053.3	MEDICARE APPROVED AMOUNT FIELD IS ZERO			MA04	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.

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L053.4	MEDICARE APPROVED AMOUNT FIELD IS NEGATIVE			MA04	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.
L054.1	NON-FFS REIMBURSEMENT TYPE, PROVIDER NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N95	This provider type may not bill this service
L056.1	REVENUE CODE 183 OR 185 BEFORE 07/01/91 NOT COVERED BY MED-QUEST	96	Non-covered charge(s).	M50	Incomplete/invalid revenue code(s).
L056.2	REVENUE CODE 183 OR 185 BEFORE 07/01/91 NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).	M50	Incomplete/invalid revenue code(s).
L056.3	REVENUE CODE 183 OR 185 BEFORE 07/01/91 COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L058.1	PHARMACY ITEM WITH DESI; NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L058.2	PHARMACY ITEM WITH DESI; NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).		
L058.3	PHARMACY ITEM WITH DESI; COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L059.1	RECIPIENT'S AGE NOT APPROPRIATE FOR CRS; NOT COVERED BY MED-QUEST	96	Non-covered charge(s).		
L059.2	RECIPIENT'S AGE NOT APPROPRIATE FOR CRS; NOT COVERED FOR DOS SPAN	96	Non-covered charge(s).		
L059.3	RECIPIENT'S AGE NOT APPROPRIATE FOR CRS; COVERAGE REQUIRES PRIOR AUTH.	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L060.1	PROCEDURE MODIFIER #1 FIELD IS MISSING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L060.2	PROCEDURE MODIFIER #1 FIELD IS INVALID FORMAT	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L060.3	PROCEDURE MODIFIER #1 FIELD IS NOT ON FILE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L061.1	PROCEDURE MODIFIER #2 FIELD IS MISSING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L061.2	PROCEDURE MODIFIER #2 FIELD IS INVALID FORMAT	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L061.3	PROCEDURE MODIFIER #2 FIELD IS NOT ON FILE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L062.1	DIAG/PROC INDICATES STERILIZATION CLAIM; ATTACHMENTS REQUIRED			N28	Consent form requirements not fulfilled.
L065.1	DME SERVICE; PROCEDURE MODIFIER CODE IS MISSING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L065.2	DME SERVICE; PROCEDURE MODIFIER CODE IS INVALID	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
L066.1	REVENUE CODE/BILL TYPE CODE INVALID COMBINATION OF CODES			M50	Incomplete/invalid revenue code(s).
L067.1	RECIPIENT HAS PART B; MEDICARE DATA MUST BE INDICATED, IS MISSING	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92	Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.
L067.2	RECIPIENT HAS PART B; MEDICARE DATA STARTS BETWEEN SERVICE DATES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L069.1	RECIPIENT HAS OTHER INSURANCE; TPL DATA MUST BE INDICATED, IS MISSING			MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
L069.2	RECIPIENT HAS OTHER INSURANCE; TPL DATA STARTS BETWEEN SERVICE DATES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		
L107.2	DIALYSIS REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L107.3	DIALYSIS REQUIRES PRIOR AUTHORIZATION; P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L107.4	DIALYSIS REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L107.5	DIALYSIS REQUIRES PRIOR AUTHORIZATION; SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L107.6	DIALYSIS REQUIRES PRIOR AUTHORIZATION; P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L108.1	OBSERVATION REQUIRES PRIOR AUTHORIZATION PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L108.2	OBSERVATION REQUIRES PRIOR AUTHORIZATION P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L108.3	OBSERVATION REQUIRES PRIOR AUTHORIZATION P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L108.4	OBSERVATION REQUIRES PRIOR AUTHORIZATION SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L108.5	OBSERVATION REQUIRES PRIOR AUTHORIZATION SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L108.6	OBSERVATION REQUIRES PRIOR AUTHORIZATION P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L109.1	LTC CLAIM REQUIRES SVC PLAN OR PA PRIOR AUTHORIZATION NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L109.2	LTC CLAIM REQUIRES SVC PLAN OR PA P/A EXISTS; NOT APPROVED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L109.3	LTC CLAIM REQUIRES SVC PLAN OR PA P/A EXISTS; SERVICE DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L109.4	LTC CLAIM REQUIRES SVC PLAN OR PA SVC PLAN HAS LOWER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L109.5	LTC CLAIM REQUIRES SVC PLAN OR PA SVC PLAN HAS HIGHER CARE LEVEL	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L109.6	LTC CLAIM REQUIRES SVC PLAN OR PA P/A MISMATCH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
L110.1	PREVIOUS CLAIM HAS BUNDLED SERVICE; COMPONENT OF GROUP PREV BILLED	97	Payment is included in the allowance for another service/procedure.		
L110.2	PREVIOUS CLAIM HAS BUNDLED SERVICE; COMPONENT OF GROUP, OVERLAPPED	97	Payment is included in the allowance for another service/procedure.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L110.3	PREVIOUS CLAIM HAS BUNDLED SERVICE; GROUP W/ COMPONENT PREV PAID	97	Payment is included in the allowance for another service/procedure.		
L110.4	PREVIOUS CLAIM HAS BUNDLED SERVICE; GROUP OVERLAPPED W/ COMPONENT	97	Payment is included in the allowance for another service/procedure.		
L111.1	DAYS SUPPLIED AMOUNT FIELD IS MISSING				
L111.2	DAYS SUPPLIED AMOUNT FIELD IS NOT NUMERIC				
L111.3	DAYS SUPPLIED AMOUNT FIELD IS ZERO				
L111.4	DAYS SUPPLIED AMOUNT FIELD IS NEGATIVE				
L112.1	MODIFIER #1 NOT VALID FOR PROCEDURE; INVALID COMBINATION OF CODES	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
L113.1	MODIFIER #2 NOT VALID FOR PROCEDURE; INVALID COMBINATION OF CODES	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
L114.1	CLIA SERVICES CLAIM NOT FOUND FOR PROVIDER	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L114.2	CLIA SERVICES CLAIM NOT FOUND FOR MEDICAL SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L114.3	CLIA SERVICES CLAIM PROVIDER IS NOT AUTHORIZED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L114.4	CLIA SERVICES CLAIM NOT VALID FOR BILL TYPE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
L115.1	NONIHS/PROF SVC/KIDSCARE MUST USE HCPCS NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L115.2	NONIHS/PROF SVC/KIDSCARE MUST USE HCPCS NO RATE FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L116.1	IHS PRV MUST USE HCPCS 0009X OR W008X NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L116.2	IHS PRV MUST USE HCPCS 0009X OR W008X NO RATE FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L117.1	HOSPICE PROVIDER TYPE/REV CODE INVALID; NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N95	This provider type may not bill this service
L117.2	HOSPICE PROVIDER TYPE/REV CODE INVALID; NO RATE FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L118.1	REV CODE MUST HAVE BILL TYPE 81X OR 82X; INVALID COMBINATION OF CODES	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		
L119.1	NO RATE SCHEDULE FOR PROVIDER TYPE; NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N95	This provider type may not bill this service
L119.2	NO RATE SCHEDULE FOR PROVIDER TYPE; NO RATE FOUND			N95	This provider type may not bill this service
L120.1	NON-IHS PROVIDER W/REV CODE 100-101; NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N95	This provider type may not bill this service
L120.2	NON-IHS PROVIDER W/REV CODE 100-101; NO RATE FOUND				
L122.1	ANGIOPLASTY W/HEART CATHETERIZATION; MODIFIER '51' ADDED	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
L122.2	ANGIOPLASTY W/HEART CATHETERIZATION; HEART CATH PAID W/O MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L123.1	MERCY CARE CLAIM W/O 'FP' MODIFIER; UNACCEPTABLE W/ MED-QUEST POLICY	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
L125.2	DIAGNOSIS CODE INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L126.2	HCPCS PROCEDURE INDICATES ABORTION; P/A REQUIRED BUT NOT FOUND	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
L130.1	HOSPICE REVENUE CODE; NON-ALTCS/NON-EPSDT RECIPIENT	96	Non-covered charge(s).		
L130.2	HOSPICE REVENUE CODE; NON-ALTCS RECIPIENT	96	Non-covered charge(s).		
L130.3	HOSPICE REVENUE CODE; NON-EPSDT RECIPIENT	96	Non-covered charge(s).		
L131.1	SPEECH/OCCUPATIONAL THERAPY IN HOME; NON-ALTCS/NON-EPSDT RECIPIENT	96	Non-covered charge(s).		
L131.2	SPEECH/OCCUPATIONAL THERAPY IN HOME; NON-ALTCS RECIPIENT	96	Non-covered charge(s).		
L131.3	SPEECH/OCCUPATIONAL THERAPY IN HOME; NON-EPSDT RECIPIENT	96	Non-covered charge(s).		
L134.1	OTHER SURGERY FOUND FOR RCP/PRV/DOS; NEAR DUPLICATE CLAIM	18	Duplicate claim/service.		
L134.2	OTHER SURGERY FOUND FOR RCP/PRV/DOS; DUPLICATE CLAIM	18	Duplicate claim/service.		
L134.3	OTHER SURGERY FOUND FOR RCP/PRV/DOS; DATE CROSSOVER DUPLICATE CLAIM	18	Duplicate claim/service.		
L134.4	OTHER SURGERY FOUND FOR RCP/PRV/DOS; NEAR DUP / ASSISTANT SURGERY	18	Duplicate claim/service.		
L137.1	RECIPIENT IS QMB ONLY; INVALID ELIGIBILITY	31	Claim denied as patient cannot be identified as our insured.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
L137.2	RECIPIENT IS QMB ONLY; INVALID ENROLLMENT	31	Claim denied as patient cannot be identified as our insured.		
L140.1	INVALID CODING COMBINATION; MUTUALLY EXCLUSIVE CODE PAID	97	Payment is included in the allowance for another service/procedure.		
L140.2	INVALID CODING COMBINATION; COMPONENT PREVIOUSLY PAID	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
L140.3	INVALID CODING COMBINATION; COMPREHENSIVE PREVIOUSLY PAID	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
L140.4	INVALID CODING COMBINATION; MULTIPLE COMPONENT CODES	97	Payment is included in the allowance for another service/procedure.		
L140.5	INVALID CODING COMBINATION; VENTILATOR MGMT WITH E/M CODE	97	Payment is included in the allowance for another service/procedure.		
L140.6	INVALID CODING COMBINATION; DISCHARGE MGMT WITH E/M CODE	97	Payment is included in the allowance for another service/procedure.		
L142.1	KIDS CARE RECIPIENT; MIDWIFE NOT AUTHORIZED TO BILL FOR SVC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N95	This provider type may not bill this service
L142.2	KIDS CARE RECIPIENT; MIDWIFE NO RATE FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
L143.1	RECIPIENT IS KIDS CARE DIRECT SERVICES; INVALID ELIGIBILITY	31	Claim denied as patient cannot be identified as our insured.		
L143.2	RECIPIENT IS KIDS CARE DIRECT SERVICES; INVALID ENROLLMENT	31	Claim denied as patient cannot be identified as our insured.		
L144.1	PLEASE CONTACT TRBHA; POSSIBLE SUBVENTION	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
P001.5	TIER BASED EDIT (HEADER); PSYCH TIER - SVC CVR UNDER DHS	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
P001.7	TIER BASED EDIT (HEADER); ALLW AMT > $300 OVER BILLED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		

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Edit/ Result Code	**Description**	**Adjust Reason Code**	**Description**	**Remark Code**	**Description**
P002.1	NON-TIER BASED EDITS (HEADER); MHS COVERED UNDER CAPTN TO DHS	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
P002.2	NON-TIER BASED EDITS (HEADER); NON-EMG PSY NOT AN MED-QUEST BNFT	96	Non-covered charge(s).		
P002.3	NON-TIER BASED EDITS (HEADER); MEDICARE AMOUNTS ARE ZERO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		
P003.2	VALUATION / PRICING EDITS (HEADER); 80% VLTN - NO RATE SCHDL FOUND	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P003.3	VALUATION / PRICING EDITS (HEADER); NO RATE SCHDL FND - MANDATORY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P003.4	VALUATION / PRICING EDITS (HEADER); NO RATE SCHDL FND - OPTIONAL	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P003.5	VALUATION / PRICING EDITS (HEADER); COIN/DEDCT EXCEEDS BILL/ALLWD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P003.6	VALUATION / PRICING EDITS (HEADER); PRIOR CB/PB/TRNSFR NOT APPLIED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P004.1	OUTLIER EDITS; CLAIM ELIGIBLE FOR OUTLIER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P004.2	OUTLIER EDITS; OUTLIER BYPASSED - CUTBACKS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P004.3	OUTLIER EDITS; OUTLIER BYPASSED - SUBACUTE PA	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
P004.4	OUTLIER EDITS; OUTLIER BYPASSED - MEDICARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		

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P004.5	OUTLIER EDITS; OUTLIER BYPASSED - PLAN PAID	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		