MAPPING OF MED-QUEST CLAIM REASON CODES TO HIPAA ADJUSTMENT REASON AND REMARK CODES ON THE 835 REMITTANCE ADVICE TRANSACTION
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- Mapped Med-QUEST Claim Reason Code values appear on the matrix below in Med-QUEST Reason Code sequence. Med-QUEST Edit/Result Codes are mapped separately.
- 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.
- Both Adjustment Reason and Remark Codes are “unduplicated” on the 835. This means that particular code values will appear only once when multiple HPMMIS Reason Codes for a claim or line translate to the same code values on the 835.

MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason 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 co-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 a “OA” CAS Segment represents a separate payment from another carrier 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.**		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason 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.					
AD002	DENIED PER MEDICAL REVIEW			N109	This claim was chosen for complex review and was denied after reviewing the medical records.
AD003	CLAIM CHARGES SHOULD BE COMBINED	B15	Payment adjusted because this procedure/service is not paid separately		

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD004	DOCUMENTATION VS. MEDICAL NECESSITY			N109	This claim was chosen for complex review and was denied after reviewing the medical records.
AD005	NON-COVERED CHARGES	96	Non-covered charges.		
AD007	NEED ADDITIONAL DOCUMENTATION PER MED RV			N66	Claim lacks necessary documentation.
AD009	DUPLICATE CLAIM	18	Duplicate claim/service.		
AD010	CONTACT CLAIM SERVICES				**Proposed Remark Code not yet final:** Call help desk.
AD012	EOMB REQUIRED			N4	Prior insurance carrier EOB received was insufficient.
AD013	PROVIDER NOT ELIGIBLE FOR SURGICAL TIER	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/perform the service billed.		
AD015	EOMB DOES NOT MATCH CLAIM			N4	Prior insurance carrier EOB received was insufficient.
AD016	FEDERAL CONSENT FORM NOT SIGNED			N28	Consent form requirements not fulfilled.
AD017	FED CONSENT FORM NOT DATED ON PHY STMNT			N28	Consent form requirements not fulfilled.
AD018	DOS NOT >30 DAYS FROM CONSENT FORM DATE			N28	Consent form requirements not fulfilled.
AD019	FEDERAL CONSENT FORM DATE EXPIRED			N28	Consent form requirements not fulfilled.
AD020	DOS MUST BE >72 HOURS FROM CONSENT DATE			N28	Consent form requirements not fulfilled.
AD021	FEDERAL CONSENT FORM REQUIRED			N28	Consent form requirements not fulfilled.
AD022	FAM PLAN PROC N/C	96	Non-covered charges.		
AD023	MUST REPORT MEDICARE COINS./DEDUCTIBLE	2	Coinsurance Amount		

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD024	DENIED FOR BUNDLED SERVICES	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
AD026	RCP. NAME/DATE OF BIRTH NOT MATCHED	140	Patient/Insured health identification number and name do not match.		
AD027	CAPPED ENROLLMENT FOR PARTIAL DOS SPAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
AD028	FEDERAL CONSENT FORM NOT COMPLETE			N28	Consent form requirements not fulfilled.
AD031	RECIP HAS OTHER INS; MUST BE BILLED FIRST	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
AD033	IHS REFERRAL DOES NOT MATCH CLAIM	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
ADO34	1ST 90 DAYS OF LTC/HEALTH PLAN RESPONSIBLE	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
AD035	NO COINSURANCE/DEDUCTIBLE DUE ON SERVICE	2	Coinsurance amount.		
AD036	MUST BILL WITH PRESCRIBING PROVIDER ID	B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.		
AD038	REQUESTED DOCUMENTATION NOT RECEIVED			N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
AD040	PHARMACY MUST BE BILLED ON PHARMACY FORM			N34	Incorrect claim form for this service.

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD041	BILL E/R FACILITY CHARGES ON O/P UB92			N34	Incorrect claim form for this service.
AD042	SEND DR'S ORDER FOR TEST(S)			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
AD043	DIAG NOTES OR DR'S PROGRESS NOTES REQ			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
AD044	SEND DIAG CODES & DR'S ORDER FOR TEST			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
AD045	INVALID BILL TYPE FOR SERVICE REPORTED	5	The procedure code/bill type is inconsistent with the place of service.		
AD046	SEND PROG NOTES & DR'S ORDER FOR TESTS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
AD052	REVENUE CODE 175 NO LONGER VALID			M50	Incomplete/invalid revenue code(s)
AD053	RECIPIENT IS QMB MEDICARE ELIG. ONLY	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.		
AD056	DIAG NOT MATCHED ON PRIOR AUTH	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
AD057	PROVIDER MUST BILL DESDD OR HEALTH PLAN	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
AD058	PAID AS PART OF TRANSPLANT PACKAGE	97	Payment is included in the allowance for another service/procedure.		
AD059	FEDERAL CONSENT FORM NOT SIGNED OR DATED			N28	Consent form requirements not fulfilled.
AD060	PRENATAL SERVICES NOT COVERED >= 7/1/97	96	Non-covered charge(s).		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD062	PROVIDER ID DOES NOT MATCH NAME	M57	Incomplete/invalid provider number.		
AD063	RECEIVED GREATER THAN 12 MONTHS FROM DOS	29	The time limit for filing has expired.		
AD064	INCLUDED IN BASE CODE	97	Payment is included in the allowance for another service/procedure.		
AD070	SERVICE INCLUDED IN COMPOSITE RATE	97	Payment is included in the allowance for another service/procedure.		
AD071	PROVIDER NOT CERTIFIED LICENSED FOR LAB.	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
AD072	LABORATORY SVCS. MUST BE BILLED BY LAB.	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.		
AD073	NO DOC. TO SUPPORT MEDICAL NECESSITY			N66	Claim lacks necessary documentation.
AD074	DOC. DOES NOT SUPPORT MEDICAL NECESSITY			N66	Claim lacks necessary documentation.
AD075	DOC. DOES NOT SUPPORT SERVICES/CHARGES			N66	Claim lacks necessary documentation.
AD076	SERVICE NOT RELATED TO ESRD CONDITION	96	Non-covered charge(s).		
AD077	EPO DENIED BECAUSE HEMATOCRIT > 36%	96	Non-covered charge(s).		
AD078	EPO DENIED BECAUSE HEMATOCRIT AVG. >36%	96	Non-covered charge(s).		
AD079	EPO DENIED - HEMATOCRIT NOT ON CLAIM	96	Non-covered charge(s).		
AD082	TOTAL EPO>100,000 UNITS;SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/report/invoice needed to adjudicate.

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD083	EPO>10,000 UNITS/ADMIN; SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD084	HEMODIALYSIS >14 UNITS; SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD085	UNITS/CHARGE FLD. MISSING;LINE NON-CVRD.	96	Non-covered charge(s).		
AD086	SPLIT DIALYSIS BILL NOT ALLOWED	96	Non-covered charge(s).		
AD088	TESTS NOT ORDER BY PHYSICIAN	96	Non-covered charge(s).		
AD091	SEND PROGRESS NOTES			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD092	SEND LAB TEST RESULTS			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD093	SEND PHYSICIANS ORDERS			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD094	SEND PATIENT HISTORY AND PHYSICAL			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
AD095	SEND ITEMIZED STATEMENT			N26	Itemized bill required for claim adjudication.
AD101	INCORRECT PROCEDURE CODE FOR SERVICE			N56	Procedure code billed is not correct for the service billed.
AD198	BILLED CHARGES DO NOT MATCH EOMB			N4	Prior insurance carrier EOB received was insufficient.
AD199	RECEIVED GREATER THAN 9 MONTHS FROM DOS	29	The time limit for filing has expired.		
AD200	RECEIVED MORE THAN 6 MONTHS FROM DOS	29	The time limit for filing has expired.		

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
AD235	UNCLEAR RECIPIENT DESIGNATION	31	Claim denied as patient cannot be identified as our insured.		
AD333	ALREADY PAID FFS; RECOUP DUPLICATE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
AD800	REDENIAL OF A PREVIOUSLY DENIED CLAIM	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
AD850	ALREADY PAID-BILLED TO APACHE COUNTY	23	Payment adjusted because charges have been paid by another payer.		
AD851	ALREADY PAID-BILLED TO NAVAJO COUNTY	23	Payment adjusted because charges have been paid by another payer.		
AD875	ALREADY DENIED-BILLED TO APACHE CTY.	23	Payment adjusted because charges have been paid by another payer.		
AD876	ALREADY DENIED-BILLED TO NAVAJO COUNTY	23	Payment adjusted because charges have been paid by another payer.		
AD878	RCP. ENROLLED IN HEALTH PLAN PARTIAL DOS	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		
AD900	CTY ELIG. DENIED/PREV. PAID	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
AD901	CTY ELIG. DENIED OR USED TOWARDS SPND DW	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.		
AD950	APACHE COUNTY RESPONSIBILITY	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
AD951	NAVAJO COUNTY RESPONSIBILITY	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		
MC011	NOT AN MED-QUEST COVERED SERVICE	96	Non-covered service(s).		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MC012	REDUCED BY MEDICAL REVIEW OUTCOME	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC013	REDUCED BY MANUAL PRICING	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC014	OPI REVIEW RESULTED IN UNITS DECREASE	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC015	UNIT(S)-1500 CUTBACK AFTER MED REVIEW	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC016	DOCUMENTATION DSN'T SUPPRT LNGTH OF STAY	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N29	Required documentation/orders/notes/summary report/invoice needed to adjudicate.
MC018	CUTBACK OF GLOBAL CODE TO DELIVERY ONLY	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MC019	CUTBACK OF POSTPARTUM CHARGES	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC031	LESSER TIER LEVEL PER DOCUMENTATION	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC032	CMRU TIER CUTBACK FROM NICU (C)	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC033	CMRU TIER CUTBACK FROM ICU (C)	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MC040	SERVICE INCLUDED IN COMPOSITE RATE	97	Payment is included in the allowance for another service/procedure.		
MC041	PROVIDER NOT CERTIFIED/LICENSED FOR LAB.	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
MC042	LAB SERVICES MUST BE BILLED BY LAB PROV.	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/perform the service billed.		
MC043	NO DOC./ACCEPTABLE DX TO SUPPORT NECESSI	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MC044	DOC. DOES NOT SUPPORT MEDICAL NECESSITY	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC045	DOC. DOES NOT SUPPORT SERVICES/CHARGES	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC046	SERVICE NOT RELATED TO ESRD	96	Non-covered charge(s).		
MC047	EPO DENIED - HEMATOCRIT > 36%	96	Non-covered charge(s).		
MC048	EPO DENIED - HEMAOTCRIT ROLLING AVG.>36%	96	Non-covered charge(s).		
MC049	EPO DENIED - HEMATOCRIT NOT ON CLAIM	96	Non-covered charge(s).		
MC052	REVENUE CODE NOT COVERED FOR DIALYSIS	96	Non-covered charge(s).		
MC053	CPT/HCPCS CODING INCORRECT/MISSING			N56	Procedure code billed is not correct for the service billed.
MC054	TOTAL EPO>100,000 UNITS;SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC055	EPO>10,000 UNITS/ADMIN; SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC056	HEMODIALYSIS>14 UNITS; SUBMIT DOCUMENTS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC057	VACCINES/TB TST NOT CVRD FOR ESP RCPTS.	96	Non-covered charge(s).		

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MC060	UNITS/CHARGE FLD MISSING;LINE NON-CVRD.	96	Non-covered charge(s).		
MC061	SEND PROGRESS NOTES			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC062	SEND LAB TEST RESULTS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MC063	SEND PHYSICIANS ORDERS			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
MC064	SEND PATIENT HISTORY AND PHYSICAL			N29	Required documentation/orders/notes/summary/report/ invoice needed to adjudicate.
MC065	SEND ITEMIZED STATEMENT			N26	Itemized bill required for claim adjudication.
MD001	MEDICAL REVIEW DENIAL			N109	This claim was chosen for complex review and was denied after reviewing the medical records.
MD002	DENY/STERIL. CONSENT FORM NOT ATTACHED			N28	Consent form requirements not fulfilled.
MD003	RESUBMIT WITH ITEMIZED BILL			N26	Itemized bill required for claim adjudication.
MD004	RESUBMIT WITH H&P			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD005	RESUBMIT WITH OPERATIVE REPORT			M29	Claim lacks the operative report.
MD006	RESUBMIT WITH DISCHARGE SUMMARY			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD007	RESUBMIT WITH PATHOLOGY REPORT			M30	Claim lacks the pathology report.

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MD008	RESUBMIT WITH PROGRESS NOTES			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD009	RESUBMIT WITH MEDICATION RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD010	RESUBMIT WITH NURSES NOTES			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD011	RESUBMIT WITH PHYSICIANS ORDERS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD012	RESUBMIT WITH ANESTHESIA RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD013	RESUBMIT WITH LABOR/DELIVERY RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD014	RESUBMIT WITH PROCEDURE RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD015	RESUBMIT WITH CONSULT REPORT			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD016	RESUBMIT WITH X-RAY REPORT			M31	Claim lacks the radiology report.
MD017	RESUBMIT WITH ULTRASOUND REPORT			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD018	RESUBMIT WITH EMERGENCY ROOM RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MD019	RESUBMIT WITH OFFICE/CLINIC NOTES			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD020	RESUBMIT WITH TRANSPORT RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD021	RESUBMIT WITH OBSERVATION ORDERS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD022	RESUBMIT WITH OBSERVATION RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD023	RESUBMIT WITH H&P, OP,D/C, ER RECORDS			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD024	RESUBMIT WITH MD ORDERS & PROGRESS NOTES			N29	Required documentation/orders/notes/summary/ report/invoice needed to adjudicate.
MD025	RESUBMIT WITH STERILIZATION CHGS REMOVED	96	Non-covered charge(s).		
MD026	RESUBMIT ON A UB-92 FORM			N34	Incorrect claim form for this service.
MD028	NOT AN ESP COVERED SERVICE	96	Non-covered charge(s).		
MD029	NON-ACUTE PSYCH SERVICES NOT COVERED	96	Non-covered charge(s).		
MD030	TRANS NOT COVERED BEYOND NEAREST FACIL	96	Non-covered charge(s).		
MD031	SERVICES DENIED PER CONCURRENT REVIEW			N109	This claim was chosen for complex review and was denied after reviewing the medical records.
MD032	STERILIZATION-MEMBER NOT 21 YRS OLD	96	Non-covered charge(s).		

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Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MD033	DOES NOT MEET OBSERVATION CRITERIA			N109	This claim was chosen for complex review and was denied after reviewing the medical records.
MD034	EMERGENCY CRITERIA NOT MET	40	Charges do not meet qualifications for emergent/urgent care.		
MD035	LENGTH OF STAY NOT SUBSTANTIATED			N66	Claim lacks necessary documentation.
MD036	CHARGES NOT SUBSTANTIATED			N66	Claim lacks necessary documentation.
MD037	SERVICES REQUIRE PA	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
MD038	CHGS/SERVICES DO NOT MATCH DOCUMENTATION			N66	Claim lacks necessary documentation.
MD039	MEDICAL RECORDS DO NOT MATCH DOS BILLED			N66	Claim lacks necessary documentation.
MD040	REQUESTED DOCUMENTATION NOT RECEIVED			N66	Claim lacks necessary documentation.
MD041	NO MEDICAL DOCUMENTATION SUBMITTED			N66	Claim lacks necessary documentation.
MD042	ALS LEVEL OF SERVICE NOT SUBSTANTIATED			N66	Claim lacks necessary documentation.
MD043	ACUTE PSYCH EPISODE NOT DOCUMENTED			N66	Claim lacks necessary documentation.
MD044	EMERG ROOM MUST BE BILLED AS INPATIENT			N34	Incorrect claim form for this service.
MD045	INCIDENTAL PROCEDURES NOT COVERED	96	Non-covered charge(s).		
MD046	PROCEDURE INVALID FOR FAMILY PLANNING			N56	Procedure code billed is not correct for the service billed.
MD048	NEAR DUPLICATE OF PAID PROCEDURE	18	Duplicate claim/service.		

MAPPING OF MED-QUEST CLAIM REASON CODES TO HIPAA ADJUSTMENT REASON AND REMARK CODES ON THE 835 REMITTANCE ADVICE TRANSACTION
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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MD050	CPT CODING INCORRECT			N56	Procedure code billed is not correct for the service billed.
MD051	HCPCS CODING INCORRECT			N56	Procedure code billed is not correct for the service billed.
MD054	ASSISTANT SURGEON MUST BILL SEPARATELY			N32	Provider performing service must submit claim.
MD055	ORIGINAL CLAIM WAS PAID CORRECTLY	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
MD056	INCLUDED IN GLOBAL PACKAGE	97	Payment is included in the allowance for another service/procedure.		
MD057	INCLUDED IN PRIOR CHARGE	97	Payment is included in the allowance for another service/procedure.		
MD058	BUNDLED INTO OTHER PROCEDURE	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
MD059	RESUBMIT WITHOUT MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
MD060	INVALID MODIFIER COMBINATION	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).
MD061	INMATE OF A PUBLIC INSTITUTION	31	Claim denied as patient cannot be identified as our insured.		
MD063	FEDERAL CONSENT FORM NOT SIGNED			N28	Consent form requirements not fulfilled.
MD064	FEDERAL CONSENT FORM DATE EXPIRED			N28	Consent form requirements not fulfilled.
MD065	CO-SURGERY NOT REIMBURSABLE	96	Non-covered charge(s).		
MD066	MODIFIER MISSING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
MD067	INCORRECT MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
MD070	AUTHORIZATION FOR SERVICES DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
MD071	NOT AN MED-QUEST COVERED SERVICE	96	Non-covered charge(s).		
MD080	UNABLE TO DETERMINE PREG./EMG. FROM DX.	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
MD230	TEST INC. IN COMPOSITE;SEND PROG. NOTES			N66	Claim lacks necessary documentation.
MD231	LAB TEST. REQUIRES PROGRESS NOTES			N66	Claim lacks necessary documentation.
SC001	PA UNITS PARTIALLY USED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC020	PSYCHIATRIC EPISODE > THAN 3 DAYS	35	Benefit maximum has been reached.		
SC021	PSYCH LIMIT FOR CONTRACT YEAR EXCEEDED	119	Benefit maximum for this time period has been reached.		
SC022	DETOX SERVICE LIMITS EXCEEDED	35	Benefit maximum has been reached.		
SC023	ICU/NICU W/O PA CUTBACK TO 1 DAY	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC024	NON ICU/NICU W/O PA CB TO 3 DAYS	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC025	LENGTH OF STAY CUTBACK/PA EXCEEDED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC026	NURSERY STAY EXCEEDS 3 DAYS FOR ESP	35	Benefit maximum has been reached.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
SC027	INTERIM BILL W/O PA CUT TO 3 DAYS	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC028	KIDSCARE BH 30 INPATIENT LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC029	KIDSCARE BH 30 VISIT LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC030	OXYGEN/SUPPLIES, W/O TRANSPORTATION PA	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.		
SC031	KIDSCARE VISION EXAM LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC032	KIDSCARE VISION LENS LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC033	IMD LIMITS EXCEEDED->30 CONSEC DAYS	35	Benefit maximum has been reached.		
SC034	IMD LIMITS EXCEEDED->60 DAYS/FISCAL YR	35	Benefit maximum has been reached.		
SC040	ANESTHESIA MAX. VALUE EXCEEDED	35	Benefit maximum has been reached.		
SC041	SELF DIALYSIS TRAINING LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC042	BIRTHING CENTER SERVICE LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC043	RESPITE SERVICE LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC044	BED HOLD DAYS EXCEEDED	35	Benefit maximum has been reached.		
SC045	THERAPEUTIC DAYS LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC046	DAILY SERVICE LIMIT EXCEEDED	35	Benefit maximum has been reached.		
SC050	SYSTEM CUTBACK TO LOWER CARE LEVEL	A2	Contractual adjustment.		
SC060	FREQUENCY LIMIT EXCEEDED/LIFETIME	35	Benefit maximum has been reached.		

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MED-QUEST CODES		HIPAA CODES ON THE 835 TRANSACTION			
Reason Code	Description	Adjust Reason Code	Description	Remark Code	Description
SC061	FREQUENCY LIMIT EXCEEDED/OTHER	35	Benefit maximum has been reached.		
SC062	LTC SERVICE LIMIT DAYS EXCEEDED	35	Benefit maximum has been reached.		
SC080	NCVRD CHRGS APPLIED/ REV CD NOT CV	96	Non-covered charge(s).		
SC083	ALLOWED SERVICE UNITS EXCEEDED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
SC085	DELIVERY ONLY	96	Non-covered charge(s).		
SC086	POSTPARTUM DISALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.		
SC200	SYSTEM CUTBACK TO LOWER TIER	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
SC400	REVENUE CODE NOT COVERED	96	Non-covered charge(s).		
SC401	REVENUE CODE NOT COVERED FOR BILL TYPE	96	Non-covered charge(s).		
SC999	NET ALLOW OFFSET	88	Adjustment amount represents collection against receivable created in prior overpayment.		