How to Search the Remark Code Lookup Document

1. Hold Control Key and Press F
2. A Search Box will be displayed in the upper right of the screen
3. Enter your search criteria (Remark Code)
4. Click the NEXT button in the Search Box to locate the Remark code you are inquiring on

REMARK CODES	DESCRIPTION
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
	Start: 01/01/1997
M2	Not paid separately when the patient is an inpatient.
	Start: 01/01/1997
M3	Equipment is the same or similar to equipment already being used.
	Start: 01/01/1997
M4	Alert: This is the last monthly installment payment for this durable medical equipment.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
	Start: 01/01/1997
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
	Start: 01/01/1997 | Last Modified: 03/01/2009
	Notes: (Modified 4/1/07, 3/1/2009)
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
	Start: 01/01/1997
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
	Start: 01/01/1997
M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
	Start: 01/01/1997
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
	Start: 01/01/1997
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
	Start: 01/01/1997
M13	Only one initial visit is covered per specialty per medical group.
	Start: 01/01/1997 | Last Modified: 06/30/2007
	Notes: (Modified 6/30/03)
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
	Start: 01/01/1997
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
	Start: 01/01/1997

M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Reactivated 4/1/04, Modified 11/18/05, 4/1/07)
M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
M19	Missing oxygen certification/re-certification.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N234
M20	Missing/incomplete/invalid HCPCS.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M22	Missing/incomplete/invalid number of miles traveled.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M23	Missing invoice.
	Start: 01/01/1997 | Last Modified: 08/01/2005
	Notes: (Modified 8/1/05)
M24	Missing/incomplete/invalid number of doses per vial.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
	Start: 01/01/1997 | Last Modified: 11/01/2010
	Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.
	The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
	Start: 01/01/1997 | Last Modified: 08/01/2007
	Notes: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
	Start: 01/01/1997
M29	Missing operative note/report.
	Start: 01/01/1997 | Last Modified: 07/01/2008
	Notes: (Modified 2/28/03, 7/1/2008) Related to N233
M30	Missing pathology report.
	Start: 01/01/1997 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04, 2/28/03) Related to N236
M31	Missing radiology report.
	Start: 01/01/1997 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04, 2/28/03) Related to N240
M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
	Start: 01/01/1997
M37	Not covered when the patient is under age 35.
	Start: 01/01/1997 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
M38	Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.
	Start: 01/01/1997 | Last Modified: 07/01/2015
	Notes: (Modified 7/1/15)
M39	Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
	Start: 01/01/1997 | Last Modified: 07/01/2015
	Notes: (Modified 2/1/04, 4/1/07, 11/1/09, 11/1/12, 7/1/15) Related to N563
M40	Claim must be assigned and must be filed by the practitioner's employer.
	Start: 01/01/1997
M41	We do not pay for this as the patient has no legal obligation to pay for this.
	Start: 01/01/1997
M42	The medical necessity form must be personally signed by the attending physician.
	Start: 01/01/1997

M44	Missing/incomplete/invalid condition code.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M45	Missing/incomplete/invalid occurrence code(s).
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N299
M46	Missing/incomplete/invalid occurrence span code(s).
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N300
M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
	Start: 01/01/1997 | Last Modified: 07/01/2015
	Notes: (Modified 2/28/03, 7/1/15)
M49	Missing/incomplete/invalid value code(s) or amount(s).
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M50	Missing/incomplete/invalid revenue code(s).
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M51	Missing/incomplete/invalid procedure code(s).
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N301
M52	Missing/incomplete/invalid “from” date(s) of service.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M53	Missing/incomplete/invalid days or units of service.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M54	Missing/incomplete/invalid total charges.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
	Start: 01/01/1997
M56	Missing/incomplete/invalid payer identifier.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M59	Missing/incomplete/invalid “to” date(s) of service.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M60	Missing Certificate of Medical Necessity.
	Start: 01/01/1997 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04, 6/30/03) Related to N227
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
	Start: 01/01/1997

M62	Missing/incomplete/invalid treatment authorization code.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M64	Missing/incomplete/invalid other diagnosis.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
	Start: 01/01/1997
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
	Start: 01/01/1997
M67	Missing/incomplete/invalid other procedure code(s).
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N302
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
	Start: 01/01/1997 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04)
M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
	Start: 01/01/1997 | Last Modified: 08/01/2007
	Notes: (Modified 4/1/2007, 8/1/07)
M71	Total payment reduced due to overlap of tests billed.
	Start: 01/01/1997
M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
	Start: 01/01/1997 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04)
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04)
M75	Multiple automated multichannel tests performed on the same day combined for payment.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/07)
M76	Missing/incomplete/invalid diagnosis or condition.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M77	Missing/incomplete/invalid/inappropriate place of service.
	Start: 01/01/1997 | Last Modified: 03/14/2014
	Notes: (Modified 2/28/03, 3/1/2014, 3/14/2014)
M79	Missing/incomplete/invalid charge.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

M80	Not covered when performed during the same session/date as a previously processed service for the patient.
	Start: 01/01/1997 | Last Modified: 10/31/2002
	Notes: (Modified 10/31/02)
M81	You are required to code to the highest level of specificity.
	Start: 01/01/1997 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04)
M82	Service is not covered when patient is under age 50.
	Start: 01/01/1997
M83	Service is not covered unless the patient is classified as at high risk.
	Start: 01/01/1997
M84	Medical code sets used must be the codes in effect at the time of service.
	Start: 01/01/1997 | Last Modified: 03/14/2014
	Notes: (Modified 2/1/04, 3/14/2014)
M85	Subjected to review of physician evaluation and management services.
	Start: 01/01/1997
M86	Service denied because payment already made for same/similar procedure within set time frame.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
	Start: 01/01/1997
M89	Not covered more than once under age 40.
	Start: 01/01/1997
M90	Not covered more than once in a 12 month period.
	Start: 01/01/1997
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
	Start: 01/01/1997
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
	Start: 01/01/1997
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
	Start: 01/01/1997
M95	Services subjected to Home Health Initiative medical review/cost report audit.
	Start: 01/01/1997
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
	Start: 01/01/1997
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
	Start: 01/01/1997
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
	Start: 01/01/1997
M102	Service not performed on equipment approved by the FDA for this purpose.
	Start: 01/01/1997
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
	Start: 01/01/1997
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
	Start: 01/01/1997
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
	Start: 01/01/1997
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
	Start: 01/01/1997
M109	We have provided you with a bundled payment for a tele consultation. You must send 25 percent of the tele consultation payment to the referring practitioner.
	Start: 01/01/1997
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
	Start: 01/01/1997
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/07)
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/07)
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 8/1/06, 11/5/07)
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
	Start: 01/01/1997 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/2007)
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.
	Start: 01/01/1997 | Last Modified: 03/08/2011
	Notes: (Modified 2/1/04, 3/15/11)
M117	Not covered unless submitted via electronic claim.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)

M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 2/28/03, 4/1/04)
M121	We pay for this service only when performed with a covered cryosurgical ablation.
	Start: 01/01/1997
M122	Missing/incomplete/invalid level of subluxation.
	Start: 01/01/1997 | Last Modified: 02/28/2006
	Notes: (Modified 2/28/03)
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N230
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M126	Missing/incomplete/invalid individual lab codes included in the test.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M127	Missing patient medical record for this service.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N237
M129	Missing/incomplete/invalid indicator of x-ray availability for review.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 2/28/03, 6/30/03)
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N231
M131	Missing physician financial relationship form.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N239
M132	Missing pacemaker registration form.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N235
M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
	Start: 01/01/1997
M134	Performed by a facility/supplier in which the provider has a financial interest.
	Start: 01/01/1997 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)
M135	Missing/incomplete/invalid plan of treatment.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
M137	Part B coinsurance under a demonstration project or pilot program.
	Start: 01/01/1997 | Last Modified: 11/01/2012
	Notes: (Modified 11/1/12)
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
	Start: 01/01/1997
M139	Denied services exceed the coverage limit for the demonstration.
	Start: 01/01/1997
M141	Missing physician certified plan of care.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N238
M142	Missing American Diabetes Association Certificate of Recognition.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N226
M143	The provider must update license information with the payer.
	Start: 01/01/1997 | Last Modified: 12/01/2006
	Notes: (Modified 12/1/06)
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
	Start: 01/01/1997
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)
MA02	Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 10/31/02, 6/30/03, 8/1/05, 12/29/05, 8/1/06, 4/1/07)
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.
	Start: 01/01/1997
MA07	Alert: The claim information has also been forwarded to Medicaid for review.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA08	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA09	Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.
	Start: 01/01/1997 | Last Modified: 11/01/2014

MA10	Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
	Start: 01/01/1997
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
	Start: 01/01/1997 | Last Modified: 08/01/2007
	Notes: (Modified 4/1/07, 8/1/07)
MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
	Start: 01/01/1997
MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
	Start: 01/01/1997
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA19	Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
MA21	SSA records indicate mismatch with name and sex.
	Start: 01/01/1997
MA22	Payment of less than $1.00 suppressed.
	Start: 01/01/1997
MA23	Demand bill approved as result of medical review.
	Start: 01/01/1997
MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
	Start: 01/01/1997

MA26	Alert: Our records indicate that you were previously informed of this rule.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA30	Missing/incomplete/invalid type of bill.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA32	Missing/incomplete/invalid number of covered days during the billing period.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA33	Missing/incomplete/invalid noncovered days during the billing period.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA35	Missing/incomplete/invalid number of lifetime reserve days.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA36	Missing/incomplete/invalid patient name.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA37	Missing/incomplete/invalid patient's address.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA39	Missing/incomplete/invalid gender.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA40	Missing/incomplete/invalid admission date.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA41	Missing/incomplete/invalid admission type.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA42	Missing/incomplete/invalid admission source.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

MA43	Missing/incomplete/invalid patient status.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA44	Alert: No appeal rights. Adjudicative decision based on law.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA46	The new information was considered but additional payment will not be issued.
	Start: 01/01/1997 | Last Modified: 03/01/2009
	Notes: (Modified 3/1/2009)
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
	Start: 01/01/1997
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
	Start: 01/01/1997 | Last Modified: 03/01/2014
	Notes: (Modified 2/28/03, 3/1/2014)
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
	Start: 01/01/1997 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04)
MA54	Physician certification or election consent for hospice care not received timely.
	Start: 01/01/1997
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
	Start: 01/01/1997
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
	Start: 01/01/1997
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
	Start: 01/01/1997
MA58	Missing/incomplete/invalid release of information indicator.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA60	Missing/incomplete/invalid patient relationship to insured.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

MA61	Missing/incomplete/invalid social security number or health insurance claim number.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA62	Alert: This is a telephone review decision.
	Start: 01/01/1997 | Last Modified: 08/01/2007
	Notes: (Modified 4/1/07, 8/1/07)
MA63	Missing/incomplete/invalid principal diagnosis.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
	Start: 01/01/1997
MA65	Missing/incomplete/invalid admitting diagnosis.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA66	Missing/incomplete/invalid principal procedure code.
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N303
MA67	Correction to a prior claim.
	Start: 01/01/1997
MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA69	Missing/incomplete/invalid remarks.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA70	Missing/incomplete/invalid provider representative signature.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA71	Missing/incomplete/invalid provider representative signature date.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
	Start: 01/01/1997
MA74	Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
	Start: 01/01/1997 | Last Modified: 07/01/2015
	Notes: (Modified 7/1/15)
MA75	Missing/incomplete/invalid patient or authorized representative signature.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03, 2/1/04)
MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
	Start: 01/01/1997 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
MA79	Billed in excess of interim rate.
	Start: 01/01/1997
MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
	Start: 01/01/1997
MA81	Missing/incomplete/invalid provider/supplier signature.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA83	Did not indicate whether we are the primary or secondary payer.
	Start: 01/01/1997 | Last Modified: 08/01/2005
	Notes: (Modified 8/1/05)
MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
	Start: 01/01/1997
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA90	Missing/incomplete/invalid employment status code for the primary insured.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03).
MA91	Alert: This determination is the result of the appeal you filed.
	Start: 01/01/1997 | Last Modified: 07/01/2015
	Notes: (Modified 7/1/15)
MA92	Missing plan information for other insurance.
	Start: 01/01/1997 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04) Related to N245
MA93	Non-PIP (Periodic Interim Payment) claim.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
MA94	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.
	Start: 01/01/1997 | Last Modified: 08/01/2005
	Notes: (Reactivated 4/1/04, Modified 8/1/05)

MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
	Start: 01/01/1997
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
	Start: 01/01/1997 | Last Modified: 02/29/2008
	Notes: (Modified 2/29/08)
MA99	Missing/incomplete/invalid Medigap information.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA100	Missing/incomplete/invalid date of current illness or symptoms.
	Start: 01/01/1997 | Last Modified: 03/14/2014
	Notes: (Modified 2/28/03, 3/30/05, 3/14/2014)
MA103	Hemophilia Add On.
	Start: 01/01/1997
MA106	PIP (Periodic Interim Payment) claim.
	Start: 01/01/1997 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
MA107	Paper claim contains more than three separate data items in field 19.
	Start: 01/01/1997
MA108	Paper claim contains more than one data item in field 23.
	Start: 01/01/1997
MA109	Claim processed in accordance with ambulatory surgical guidelines.
	Start: 01/01/1997
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA112	Missing/incomplete/invalid group practice information.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
	Start: 01/01/1997
MA114	Missing/incomplete/invalid information on where the services were furnished.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.
	Start: 01/01/1997
	Notes: (Reactivated 4/1/04)
MA117	This claim has been assessed a $1.00 user fee.
	Start: 01/01/1997
MA118	Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.
	Start: 01/01/1997 | Last Modified: 11/01/2014
MA120	Missing/incomplete/invalid CLIA certification number.
	Start: 01/01/1997 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
MA121	Missing/incomplete/invalid x-ray date.
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04)
MA122	Missing/incomplete/invalid initial treatment date.
	Start: 01/01/1997 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04)
MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
	Start: 01/01/1997
MA125	Per legislation governing this program, payment constitutes payment in full.
	Start: 01/01/1997
MA126	Pancreas transplant not covered unless kidney transplant performed.
	Start: 10/12/2001
MA128	Missing/incomplete/invalid FDA approval number.
	Start: 10/12/2001 | Last Modified: 03/30/2005
	Notes: (Modified 2/28/03, 3/30/05)
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
	Start: 10/12/2001
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
	Start: 10/12/2001
MA132	Adjustment to the pre-demonstration rate.
	Start: 10/12/2001
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
	Start: 10/12/2001
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
	Start: 10/12/2001
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.
	Start: 01/01/2000 | Last Modified: 07/15/2013
	Notes: (Modified 2/28/03, 4/1/07, 7/15/13)
N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
	Start: 01/01/2000

N3	Missing consent form.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03) Related to N228
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
	Start: 01/01/2000 | Last Modified: 03/06/2012
	Notes: (Modified 2/28/03, 3/6/2012)
N5	EOB received from previous payer. Claim not on file.
	Start: 01/01/2000
N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.
	Start: 01/01/2000 | Last Modified: 07/15/2013
	Notes: (Modified 7/15/13)
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
	Start: 01/01/2000
N9	Adjustment represents the estimated amount a previous payer may pay.
	Start: 01/01/2000 | Last Modified: 11/18/2005
	Notes: (Modified 11/18/05)
N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
	Start: 01/01/2000 | Last Modified: 03/01/2015
	Notes: (Modified 10/31/02, 7/1/08, 7/15/13, 3/1/2015)
N11	Denial reversed because of medical review.
	Start: 01/01/2000
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
	Start: 01/01/2000 | Last Modified: 08/01/2007
	Notes: (Modified 8/1/07)
N13	Payment based on professional/technical component modifier(s).
	Start: 01/01/2000
N15	Services for a newborn must be billed separately.
	Start: 01/01/2000
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
	Start: 01/01/2000
N19	Procedure code incidental to primary procedure.
	Start: 01/01/2000
N20	Service not payable with other service rendered on the same date.
	Start: 01/01/2000
N21	Alert: Your line item has been separated into multiple lines to expedite handling.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 8/1/05, 4/1/07)

N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
	Start: 01/01/2000 | Last Modified: 07/01/2015
	Notes: (Modified 10/31/02, 2/28/03, 7/1/15)
N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 8/13/01, 4/1/07)
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N25	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
	Start: 01/01/2000
N26	Missing itemized bill/statement.
	Start: 01/01/2000 | Last Modified: 07/01/2008
	Notes: (Modified 2/28/03, 7/1/2008) Related to N232
N27	Missing/incomplete/invalid treatment number.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N28	Consent form requirements not fulfilled.
	Start: 01/01/2000
N29	Missing documentation/orders/notes/summary/report/chart.
	Start: 01/01/2000 | Stop: 03/01/2016 | Last Modified: 03/01/2014
	Notes: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.
N30	Patient ineligible for this service.
	Start: 01/01/2000 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N31	Missing/incomplete/invalid prescribing provider identifier.
	Start: 01/01/2000 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04)
N32	Claim must be submitted by the provider who rendered the service.
	Start: 01/01/2000 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N33	No record of health check prior to initiation of treatment.
	Start: 01/01/2000
N34	Incorrect claim form/format for this service.
	Start: 01/01/2000 | Last Modified: 11/18/2005
	Notes: (Modified 11/18/05)
N35	Program integrity/utilization review decision.
	Start: 01/01/2000
N36	Claim must meet primary payer's processing requirements before we can consider payment.
	Start: 01/01/2000
N37	Missing/incomplete/invalid tooth number/letter.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)

N39	Procedure code is not compatible with tooth number/letter.
	Start: 01/01/2000
N40	Missing radiology film(s)/image(s).
	Start: 01/01/2000 | Last Modified: 07/01/2008
	Notes: (Modified 2/1/04, 7/1/08) Related to N242
N42	Missing mental health assessment.
	Start: 01/01/2000 | Last Modified: 11/01/2014
N43	Bed hold or leave days exceeded.
	Start: 01/01/2000
N45	Payment based on authorized amount.
	Start: 01/01/2000
N46	Missing/incomplete/invalid admission hour.
	Start: 01/01/2000
N47	Claim conflicts with another inpatient stay.
	Start: 01/01/2000
N48	Claim information does not agree with information received from other insurance carrier.
	Start: 01/01/2000
N49	Court ordered coverage information needs validation.
	Start: 01/01/2000
N50	Missing/incomplete/invalid discharge information.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N51	Electronic interchange agreement not on file for provider/submitter.
	Start: 01/01/2000
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
	Start: 01/01/2000
N53	Missing/incomplete/invalid point of pick-up address.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N54	Claim information is inconsistent with pre-certified/authorized services.
	Start: 01/01/2000
N55	Procedures for billing with group/referring/performing providers were not followed.
	Start: 01/01/2000
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N57	Missing/incomplete/invalid prescribing date.
	Start: 01/01/2000 | Last Modified: 12/02/2004
	Notes: (Modified 12/2/04) Related to N304
N58	Missing/incomplete/invalid patient liability amount.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N59	Please refer to your provider manual for additional program and provider information.
	Start: 01/01/2000 | Last Modified: 11/01/2009
	Notes: (Modified 4/1/07, 11/1/09)

N61	Rebill services on separate claims.
	Start: 01/01/2000
N62	Dates of service span multiple rate periods. Resubmit separate claims.
	Start: 01/01/2000 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N63	Rebill services on separate claim lines.
	Start: 01/01/2000
N64	The "from" and "to" dates must be different.
	Start: 01/01/2000
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
	Start: 01/01/2000
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
	Start: 01/01/2000
N69	PPS (Prospective Payment System) code changed by claims processing system.
	Start: 01/01/2000 | Last Modified: 07/01/2012
	Notes: (Modified 6/30/03, 7/1/12)
N70	Consolidated billing and payment applies.
	Start: 01/01/2000 | Last Modified: 11/05/2007
	Notes: (Modified 2/28/02, 11/5/07)
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
	Start: 01/01/2000 | Last Modified: 06/30/2003
	Notes: (Modified 2/21/02, 6/30/03)
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
	Start: 01/01/2000 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
	Start: 01/01/2000

N75	Missing/incomplete/invalid tooth surface information.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N76	Missing/incomplete/invalid number of riders.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N77	Missing/incomplete/invalid designated provider number.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
	Start: 01/01/2000
N79	Service billed is not compatible with patient location information.
	Start: 01/01/2000
N80	Missing/incomplete/invalid prenatal screening information.
	Start: 01/01/2000 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N81	Procedure billed is not compatible with tooth surface code.
	Start: 01/01/2000
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
	Start: 01/01/2000
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
	Start: 01/01/2000
N84	Alert: Further installment payments are forthcoming.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07, 8/1/07)
N85	Alert: This is the final installment payment.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07, 8/1/07)
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
	Start: 01/01/2000
N87	Home use of biofeedback therapy is not covered.
	Start: 01/01/2000
N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
	Start: 01/01/2000 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N90	Covered only when performed by the attending physician.
	Start: 01/01/2000

N91	Services not included in the appeal review.
	Start: 01/01/2000
N92	This facility is not certified for digital mammography.
	Start: 01/01/2000
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
	Start: 01/01/2000
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
	Start: 01/01/2000
N95	This provider type/provider specialty may not bill this service.
	Start: 07/31/2001 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
	Start: 08/24/2001
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
	Start: 08/24/2001
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
	Start: 08/24/2001
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
	Start: 08/24/2001
N100	PPS (Prospect Payment System) code corrected during adjudication.
	Start: 09/14/2001 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.
	Start: 10/31/2001 | Stop: 07/01/2016 | Last Modified: 11/01/2013
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.
	Start: 10/31/2001 | Last Modified: 11/01/2013
	Notes: (Modified 6/30/03, 7/1/12, 11/1/13)
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
	Start: 01/29/2002 | Last Modified: 07/01/2010
	Notes: (Modified 10/31/02, 7/1/10)
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
	Start: 01/29/2002

N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
	Start: 01/31/2002
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
	Start: 01/31/2002
N108	Missing/incomplete/invalid upgrade information.
	Start: 01/31/2002 | Last Modified: 02/28/2003
	Notes: (Modified 2/28/03)
N109	Alert: This claim/service was chosen for complex review.
	Start: 02/28/2002 | Last Modified: 07/01/2015
	Notes: (Modified 3/1/2009, 7/1/15)
N110	This facility is not certified for film mammography.
	Start: 02/28/2002
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
	Start: 02/28/2002
N112	This claim is excluded from your electronic remittance advice.
	Start: 02/28/2002
N113	Only one initial visit is covered per physician, group practice or provider.
	Start: 04/16/2002 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
	Start: 05/30/2002
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
	Start: 05/30/2002 | Last Modified: 07/01/2010
	Notes: (Modified 4/1/04, 7/1/10)
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
	Start: 06/30/2002
N117	This service is paid only once in a patient's lifetime.
	Start: 07/30/2002 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N118	This service is not paid if billed more than once every 28 days.
	Start: 07/30/2002
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.
	Start: 07/30/2002 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)

N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
	Start: 08/09/2002 | Last Modified: 06/30/2003
	Notes: (Modified 6/30/03)
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.
	Start: 09/09/2002 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04, 6/30/03)
N122	Add-on code cannot be billed by itself.
	Start: 09/12/2002 | Last Modified: 08/01/2005
	Notes: (Modified 8/1/05)
N123	This is a split service and represents a portion of the units from the originally submitted service.
	Start: 09/24/2002
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
	Start: 09/26/2002
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.
	The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.
	Start: 09/26/2002 | Last Modified: 08/01/2005
	Notes: (Modified 8/1/05. Also refer to N356)
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
	Start: 10/17/2002
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
	Start: 10/31/2007 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04
N128	This amount represents the prior to coverage portion of the allowance.
	Start: 10/31/2002
N129	Not eligible due to the patient's age.
	Start: 10/31/2002 | Last Modified: 08/01/2007
	Notes: (Modified 8/1/07)
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
	Start: 10/31/2002 | Last Modified: 11/01/2009
	Notes: (Modified 4/1/07, 7/1/08, 11/1/09)
N131	Total payments under multiple contracts cannot exceed the allowance for this service.
	Start: 10/31/2002

N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N133	Alert: Services for predetermination and services requesting payment are being processed separately.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N135	Record fees are the patient's responsibility and limited to the specified co-payment.
	Start: 10/31/2002
N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 8/1/04, 2/28/03, 4/1/07)
N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N140	Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
	Start: 10/31/2002
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
	Start: 10/31/2002

N143	The patient was not in a hospice program during all or part of the service dates billed.
	Start: 10/31/2002
N144	The rate changed during the dates of service billed.
	Start: 10/31/2002
N146	Missing screening document.
	Start: 10/31/2002 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04) Related to N243
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
	Start: 10/31/2002
N148	Missing/incomplete/invalid date of last menstrual period.
	Start: 10/31/2002
N149	Rebill all applicable services on a single claim.
	Start: 10/31/2002
N150	Missing/incomplete/invalid model number.
	Start: 10/31/2002
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
	Start: 10/31/2002
N152	Missing/incomplete/invalid replacement claim information.
	Start: 10/31/2002
N153	Missing/incomplete/invalid room and board rate.
	Start: 10/31/2002
N154	Alert: This payment was delayed for correction of provider's mailing address.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N156	Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.
	Start: 10/31/2002 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N157	Transportation to/from this destination is not covered.
	Start: 02/28/2003 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04)
N158	Transportation in a vehicle other than an ambulance is not covered.
	Start: 02/28/2003
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
	Start: 02/28/2003
N160	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.
	Start: 02/28/2003 | Last Modified: 02/01/2004
	Notes: (Modified 2/1/04)
N161	This drug/service/supply is covered only when the associated service is covered.
	Start: 02/28/2003

N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N163	Medical record does not support code billed per the code definition.
	Start: 02/28/2003
N167	Charges exceed the post-transplant coverage limit.
	Start: 02/28/2003
N170	A new/revised/renewed certificate of medical necessity is needed.
	Start: 02/28/2003
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.
	Start: 02/28/2003
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
	Start: 02/28/2003
N173	No qualifying hospital stay dates were provided for this episode of care.
	Start: 02/28/2003
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
	Start: 02/28/2003
N175	Missing review organization approval.
	Start: 02/28/2003 | Last Modified: 02/29/2008
	Notes: (Modified 8/1/04, 2/29/08) Related to N241
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
	Start: 02/28/2003
N177	Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 6/30/03, 4/1/07)
N178	Missing pre-operative images/visual field results.
	Start: 02/28/2003 | Last Modified: 11/01/2013
	Notes: (Modified 8/1/04, 11/1/13) Related to N244
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
	Start: 02/28/2003
N180	This item or service does not meet the criteria for the category under which it was billed.
	Start: 02/28/2003
N181	Additional information is required from another provider involved in this service.
	Start: 02/28/2003 | Last Modified: 12/01/2006
	Notes: (Modified 12/1/06)
N182	This claim/service must be billed according to the schedule for this plan.
	Start: 02/28/2003

N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N184	Rebill technical and professional components separately.
	Start: 02/28/2003
N185	Alert: Do not resubmit this claim/service.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
	Start: 02/28/2003
N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N188	The approved level of care does not match the procedure code submitted.
	Start: 02/28/2003
N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.
	Start: 02/28/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N190	Missing contract indicator.
	Start: 02/28/2003 | Last Modified: 08/01/2004
	Notes: (Modified 8/1/04) Related to N229
N191	The provider must update insurance information directly with payer.
	Start: 02/28/2003
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
	Start: 02/28/2003
N193	Specific federal/state/local program may cover this service through another payer.
	Start: 02/28/2003
N194	Technical component not paid if provider does not own the equipment used.
	Start: 02/25/2003
N195	The technical component must be billed separately.
	Start: 02/25/2003
N196	Alert: Patient eligible to apply for other coverage which may be primary.
	Start: 02/25/2003 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N197	The subscriber must update insurance information directly with payer.
	Start: 02/25/2003
N198	Rendering provider must be affiliated with the pay-to provider.
	Start: 02/25/2003
N199	Additional payment/recoupment approved based on payer-initiated review/audit.
	Start: 02/25/2003 | Last Modified: 08/01/2006
	Notes: (Modified 8/1/06)
N200	The professional component must be billed separately.
	Start: 02/25/2003

N202	Additional information/explanation will be sent separately.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 4/1/07, 11/1/09, 3/14/2014)
N203	Missing/incomplete/invalid anesthesia time/units.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months
	Start: 06/30/2003
N205	Information provided was illegible.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N206	The supporting documentation does not match the information sent on the claim.
	Start: 06/30/2003 | Last Modified: 03/06/2012
	Notes: (Modified 3/6/12)
N207	Missing/incomplete/invalid weight.
	Start: 06/30/2003 | Last Modified: 11/18/2005
	Notes: (Modified 11/18/05)
N208	Missing/incomplete/invalid DRG code.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N209	Missing/incomplete/invalid taxpayer identification number (TIN).
	Start: 06/30/2003 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N210	Alert: You may appeal this decision.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 4/1/07, 3/14/2014)
N211	Alert: You may not appeal this decision.
	Start: 06/30/2003 | Last Modified: 03/14/2014
	Notes: (Modified 4/1/07, 3/14/2014)
N212	Charges processed under a Point of Service benefit .
	Start: 02/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
	Start: 04/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).
	Start: 04/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
	Start: 04/01/2004 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)

N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
	Start: 04/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/1/2010, 3/14/2014)
N217	We pay only one site of service per provider per claim.
	Start: 08/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
	Start: 08/01/2004
N219	Payment based on previous payer's allowed amount.
	Start: 08/01/2004
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.
	Start: 08/01/2004 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N221	Missing Admitting History and Physical report.
	Start: 08/01/2004
N222	Incomplete/invalid Admitting History and Physical report.
	Start: 08/01/2004
N223	Missing documentation of benefit to the patient during initial treatment period.
	Start: 08/01/2004
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.
	Start: 08/01/2004
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.
	Start: 08/01/2004 | Stop: 03/01/2016 | Last Modified: 03/01/2014
	Notes: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.
	Start: 08/01/2004
N227	Incomplete/invalid Certificate of Medical Necessity.
	Start: 08/01/2004
N228	Incomplete/invalid consent form.
	Start: 08/01/2004
N229	Incomplete/invalid contract indicator.
	Start: 08/01/2004
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
	Start: 08/01/2004
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
	Start: 08/01/2004
N232	Incomplete/invalid itemized bill/statement.
	Start: 08/01/2004 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N233	Incomplete/invalid operative note/report.
	Start: 08/01/2004 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)

N234	Incomplete/invalid oxygen certification/re-certification.
	Start: 08/01/2004
N235	Incomplete/invalid pacemaker registration form.
	Start: 08/01/2004
N236	Incomplete/invalid pathology report.
	Start: 08/01/2004
N237	Incomplete/invalid patient medical record for this service.
	Start: 08/01/2004
N238	Incomplete/invalid physician certified plan of care.
	Start: 08/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N239	Incomplete/invalid physician financial relationship form.
	Start: 08/01/2004
N240	Incomplete/invalid radiology report.
	Start: 08/01/2004
N241	Incomplete/invalid review organization approval.
	Start: 08/01/2004 | Last Modified: 02/29/2008
	Notes: (Modified 2/29/08)
N242	Incomplete/invalid radiology film(s)/image(s).
	Start: 08/01/2004 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N243	Incomplete/invalid/not approved screening document.
	Start: 08/01/2004
N244	Incomplete/Invalid pre-operative images/visual field results.
	Start: 08/01/2004 | Last Modified: 11/01/2013
	Notes: (Modified 11/1/2013)
N245	Incomplete/invalid plan information for other insurance .
	Start: 08/01/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N246	State regulated patient payment limitations apply to this service.
	Start: 12/02/2004
N247	Missing/incomplete/invalid assistant surgeon taxonomy.
	Start: 12/02/2004
N248	Missing/incomplete/invalid assistant surgeon name.
	Start: 12/02/2004
N249	Missing/incomplete/invalid assistant surgeon primary identifier.
	Start: 12/02/2004
N250	Missing/incomplete/invalid assistant surgeon secondary identifier.
	Start: 12/02/2004
N251	Missing/incomplete/invalid attending provider taxonomy.
	Start: 12/02/2004
N252	Missing/incomplete/invalid attending provider name.
	Start: 12/02/2004
N253	Missing/incomplete/invalid attending provider primary identifier.
	Start: 12/02/2004
N254	Missing/incomplete/invalid attending provider secondary identifier.
	Start: 12/02/2004

N255	Missing/incomplete/invalid billing provider taxonomy.
	Start: 12/02/2004
N256	Missing/incomplete/invalid billing provider/supplier name.
	Start: 12/02/2004
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
	Start: 12/02/2004
N258	Missing/incomplete/invalid billing provider/supplier address.
	Start: 12/02/2004
N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
	Start: 12/02/2004
N260	Missing/incomplete/invalid billing provider/supplier contact information.
	Start: 12/02/2004
N261	Missing/incomplete/invalid operating provider name.
	Start: 12/02/2004
N262	Missing/incomplete/invalid operating provider primary identifier.
	Start: 12/02/2004
N263	Missing/incomplete/invalid operating provider secondary identifier.
	Start: 12/02/2004
N264	Missing/incomplete/invalid ordering provider name.
	Start: 12/02/2004
N265	Missing/incomplete/invalid ordering provider primary identifier.
	Start: 12/02/2004
N266	Missing/incomplete/invalid ordering provider address.
	Start: 12/02/2004
N267	Missing/incomplete/invalid ordering provider secondary identifier.
	Start: 12/02/2004
N268	Missing/incomplete/invalid ordering provider contact information.
	Start: 12/02/2004
N269	Missing/incomplete/invalid other provider name.
	Start: 12/02/2004
N270	Missing/incomplete/invalid other provider primary identifier.
	Start: 12/02/2004
N271	Missing/incomplete/invalid other provider secondary identifier.
	Start: 12/02/2004
N272	Missing/incomplete/invalid other payer attending provider identifier.
	Start: 12/02/2004
N273	Missing/incomplete/invalid other payer operating provider identifier.
	Start: 12/02/2004
N274	Missing/incomplete/invalid other payer other provider identifier.
	Start: 12/02/2004
N275	Missing/incomplete/invalid other payer purchased service provider identifier.
	Start: 12/02/2004
N276	Missing/incomplete/invalid other payer referring provider identifier.
	Start: 12/02/2004
N277	Missing/incomplete/invalid other payer rendering provider identifier.
	Start: 12/02/2004

N278	Missing/incomplete/invalid other payer service facility provider identifier.
	Start: 12/02/2004
N279	Missing/incomplete/invalid pay-to provider name.
	Start: 12/02/2004
N280	Missing/incomplete/invalid pay-to provider primary identifier.
	Start: 12/02/2004
N281	Missing/incomplete/invalid pay-to provider address.
	Start: 12/02/2004
N282	Missing/incomplete/invalid pay-to provider secondary identifier.
	Start: 12/02/2004
N283	Missing/incomplete/invalid purchased service provider identifier.
	Start: 12/02/2004
N284	Missing/incomplete/invalid referring provider taxonomy.
	Start: 12/02/2004
N285	Missing/incomplete/invalid referring provider name.
	Start: 12/02/2004
N286	Missing/incomplete/invalid referring provider primary identifier.
	Start: 12/02/2004
N287	Missing/incomplete/invalid referring provider secondary identifier.
	Start: 12/02/2004
N288	Missing/incomplete/invalid rendering provider taxonomy.
	Start: 12/02/2004
N289	Missing/incomplete/invalid rendering provider name.
	Start: 12/02/2004
N290	Missing/incomplete/invalid rendering provider primary identifier.
	Start: 12/02/2004
N291	Missing/incomplete/invalid rendering provider secondary identifier.
	Start: 12/02/2004 | Last Modified: 11/01/2010
N292	Missing/incomplete/invalid service facility name.
	Start: 12/02/2004
N293	Missing/incomplete/invalid service facility primary identifier.
	Start: 12/02/2004
N294	Missing/incomplete/invalid service facility primary address.
	Start: 12/02/2004
N295	Missing/incomplete/invalid service facility secondary identifier.
	Start: 12/02/2004
N296	Missing/incomplete/invalid supervising provider name.
	Start: 12/02/2004
N297	Missing/incomplete/invalid supervising provider primary identifier.
	Start: 12/02/2004
N298	Missing/incomplete/invalid supervising provider secondary identifier.
	Start: 12/02/2004
N299	Missing/incomplete/invalid occurrence date(s).
	Start: 12/02/2004
N300	Missing/incomplete/invalid occurrence span date(s).
	Start: 12/02/2004

N301	Missing/incomplete/invalid procedure date(s).
	Start: 12/02/2004
N302	Missing/incomplete/invalid other procedure date(s).
	Start: 12/02/2004
N303	Missing/incomplete/invalid principal procedure date.
	Start: 12/02/2004
N304	Missing/incomplete/invalid dispensed date.
	Start: 12/02/2004
N305	Missing/incomplete/invalid accident date.
	Start: 12/02/2004
N306	Missing/incomplete/invalid acute manifestation date.
	Start: 12/02/2004
N307	Missing/incomplete/invalid adjudication or payment date.
	Start: 12/02/2004
N308	Missing/incomplete/invalid appliance placement date.
	Start: 12/02/2004
N309	Missing/incomplete/invalid assessment date.
	Start: 12/02/2004
N310	Missing/incomplete/invalid assumed or relinquished care date.
	Start: 12/02/2004
N311	Missing/incomplete/invalid authorized to return to work date.
	Start: 12/02/2004
N312	Missing/incomplete/invalid begin therapy date.
	Start: 12/02/2004
N313	Missing/incomplete/invalid certification revision date.
	Start: 12/02/2004
N314	Missing/incomplete/invalid diagnosis date.
	Start: 12/02/2004
N315	Missing/incomplete/invalid disability from date.
	Start: 12/02/2004
N316	Missing/incomplete/invalid disability to date.
	Start: 12/02/2004
N317	Missing/incomplete/invalid discharge hour.
	Start: 12/02/2004
N318	Missing/incomplete/invalid discharge or end of care date.
	Start: 12/02/2004
N319	Missing/incomplete/invalid hearing or vision prescription date.
	Start: 12/02/2004
N320	Missing/incomplete/invalid Home Health Certification Period.
	Start: 12/02/2004
N321	Missing/incomplete/invalid last admission period.
	Start: 12/02/2004
N322	Missing/incomplete/invalid last certification date.
	Start: 12/02/2004
N323	Missing/incomplete/invalid last contact date.
	Start: 12/02/2004

N324	Missing/incomplete/invalid last seen/visit date.
	Start: 12/02/2004
N325	Missing/incomplete/invalid last worked date.
	Start: 12/02/2004
N326	Missing/incomplete/invalid last x-ray date.
	Start: 12/02/2004
N327	Missing/incomplete/invalid other insured birth date.
	Start: 12/02/2004
N328	Missing/incomplete/invalid Oxygen Saturation Test date.
	Start: 12/02/2004
N329	Missing/incomplete/invalid patient birth date.
	Start: 12/02/2004
N330	Missing/incomplete/invalid patient death date.
	Start: 12/02/2004
N331	Missing/incomplete/invalid physician order date.
	Start: 12/02/2004
N332	Missing/incomplete/invalid prior hospital discharge date.
	Start: 12/02/2004
N333	Missing/incomplete/invalid prior placement date.
	Start: 12/02/2004
N334	Missing/incomplete/invalid re-evaluation date.
	Start: 12/02/2004 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N335	Missing/incomplete/invalid referral date.
	Start: 12/02/2004
N336	Missing/incomplete/invalid replacement date.
	Start: 12/02/2004
N337	Missing/incomplete/invalid secondary diagnosis date.
	Start: 12/02/2004
N338	Missing/incomplete/invalid shipped date.
	Start: 12/02/2004
N339	Missing/incomplete/invalid similar illness or symptom date.
	Start: 12/02/2004
N340	Missing/incomplete/invalid subscriber birth date.
	Start: 12/02/2004
N341	Missing/incomplete/invalid surgery date.
	Start: 12/02/2004
N342	Missing/incomplete/invalid test performed date.
	Start: 12/02/2004
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
	Start: 12/02/2004
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
	Start: 12/02/2004
N345	Date range not valid with units submitted.
	Start: 03/30/2005

N346	Missing/incomplete/invalid oral cavity designation code.
	Start: 03/30/2005
N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
	Start: 03/30/2005
N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.
	Start: 08/01/2005
N349	The administration method and drug must be reported to adjudicate this service.
	Start: 08/01/2005
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
	Start: 08/01/2005 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N351	Service date outside of the approved treatment plan service dates.
	Start: 08/01/2005
N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.
	Start: 08/01/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.
	Start: 08/01/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N354	Incomplete/invalid invoice.
	Start: 08/01/2005 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.
	If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position.
	If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.
	The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.
	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days
	Start: 08/01/2005 | Last Modified: 04/01/2007
	Notes: (Modified 11/18/05, Modified 4/1/07)

N356	Not covered when performed with, or subsequent to, a non-covered service.
	Start: 08/01/2005 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
	Start: 11/18/2005
N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.
	Start: 11/18/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N359	Missing/incomplete/invalid height.
	Start: 11/18/2005
N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.
	Start: 11/18/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N362	The number of Days or Units of Service exceeds our acceptable maximum.
	Start: 11/18/2005
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination.
	Start: 11/18/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.
	Start: 11/18/2005 | Last Modified: 04/01/2007
	Notes: (Modified 4/1/07)
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
	Start: 04/01/2006
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.
	Start: 04/01/2006 | Last Modified: 07/01/2008
	Notes: (Modified 4/1/07, 11/5/07, 7/1/08)
N368	You must appeal the determination of the previously adjudicated claim.
	Start: 04/01/2006
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
	Start: 04/01/2006
N370	Billing exceeds the rental months covered/approved by the payer.
	Start: 08/01/2006
N371	Alert: title of this equipment must be transferred to the patient.
	Start: 08/01/2006
N372	Only reasonable and necessary maintenance/service charges are covered.
	Start: 08/01/2006
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.
	Start: 12/01/2006

N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
	Start: 12/01/2006
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
	Start: 12/01/2006
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
	Start: 12/01/2006
N377	Payment based on a processed replacement claim.
	Start: 12/01/2006 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/07)
N378	Missing/incomplete/invalid prescription quantity.
	Start: 12/01/2006
N379	Claim level information does not match line level information.
	Start: 12/01/2006
N380	The original claim has been processed, submit a corrected claim.
	Start: 04/01/2007
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
	Start: 04/01/2007 | Last Modified: 07/01/2015
	Notes: (Modified 7/1/15)
N382	Missing/incomplete/invalid patient identifier.
	Start: 04/01/2007
N383	Not covered when deemed cosmetic.
	Start: 04/01/2007 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
	Start: 04/01/2007
N385	Notification of admission was not timely according to published plan procedures.
	Start: 04/01/2007 | Last Modified: 11/05/2007
	Notes: (Modified 11/5/07)
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
	Start: 04/01/2007 | Last Modified: 07/01/2010
	Notes: (Modified 7/1/2010)
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.
	Start: 04/01/2007 | Last Modified: 03/01/2009
	Notes: (Modified 3/1/2009)
N388	Missing/incomplete/invalid prescription number.
	Start: 08/01/2007 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N389	Duplicate prescription number submitted.
	Start: 08/01/2007

N390	This service/report cannot be billed separately.
	Start: 08/01/2007 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N391	Missing emergency department records.
	Start: 08/01/2007
N392	Incomplete/invalid emergency department records.
	Start: 08/01/2007
N393	Missing progress notes/report.
	Start: 08/01/2007 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N394	Incomplete/invalid progress notes/report.
	Start: 08/01/2007 | Last Modified: 07/01/2008
	Notes: (Modified 7/1/08)
N395	Missing laboratory report.
	Start: 08/01/2007
N396	Incomplete/invalid laboratory report.
	Start: 08/01/2007
N397	Benefits are not available for incomplete service(s)/undelivered item(s).
	Start: 08/01/2007
N398	Missing elective consent form.
	Start: 08/01/2007
N399	Incomplete/invalid elective consent form.
	Start: 08/01/2007
N400	Alert: Electronically enabled providers should submit claims electronically.
	Start: 08/01/2007
N401	Missing periodontal charting.
	Start: 08/01/2007
N402	Incomplete/invalid periodontal charting.
	Start: 08/01/2007
N403	Missing facility certification.
	Start: 08/01/2007
N404	Incomplete/invalid facility certification.
	Start: 08/01/2007
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.
	Start: 08/01/2007
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
	Start: 08/01/2007
N407	You are not an approved submitter for this transmission format.
	Start: 08/01/2007
N408	This payer does not cover deductibles assessed by a previous payer.
	Start: 08/01/2007
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
	Start: 08/01/2007

N410	Not covered unless the prescription changes.
	Start: 08/01/2007 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N418	Misrouted claim. See the payer's claim submission instructions.
	Start: 08/01/2007
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
	Start: 08/01/2007
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
	Start: 08/01/2007
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.
	Start: 08/01/2007 | Last Modified: 05/08/2008
	Notes: (Modified 2/29/08, typo fixed 5/8/08)
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program.
	Start: 08/01/2007 | Last Modified: 05/08/2008
	Notes: (Typo fixed 5/8/08)
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
	Start: 08/01/2007
N424	Patient does not reside in the geographic area required for this type of payment.
	Start: 08/01/2007
N425	Statutorily excluded service(s).
	Start: 08/01/2007
N426	No coverage when self-administered.
	Start: 08/01/2007
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.
	Start: 08/01/2007
N428	Not covered when performed in this place of service.
	Start: 08/01/2007 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N429	Not covered when considered routine.
	Start: 08/01/2007 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N430	Procedure code is inconsistent with the units billed.
	Start: 11/05/2007
N431	Not covered with this procedure.
	Start: 11/05/2007 | Last Modified: 03/08/2011
	Notes: (Modified 3/8/11)
N432	Alert: Adjustment based on a Recovery Audit.
	Start: 11/05/2007 | Last Modified: 07/01/2015
	Notes: (Modified 7/1/15)
N433	Resubmit this claim using only your National Provider Identifier (NPI).
	Start: 02/29/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)

N434	Missing/Incomplete/Invalid Present on Admission indicator.
	Start: 07/01/2008
N435	Exceeds number/frequency approved /allowed within time period without support documentation.
	Start: 07/01/2008
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made.
	Start: 07/01/2008
N437	Alert: If the injury claim is accepted, these charges will be reconsidered.
	Start: 07/01/2008
N438	This jurisdiction only accepts paper claims.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N439	Missing anesthesia physical status report/indicators.
	Start: 07/01/2008
N440	Incomplete/invalid anesthesia physical status report/indicators.
	Start: 07/01/2008
N441	This missed/cancelled appointment is not covered.
	Start: 07/01/2008 | Last Modified: 07/15/2013
	Notes: (Modified 7/15/2013)
N442	Payment based on an alternate fee schedule.
	Start: 07/01/2008
N443	Missing/incomplete/invalid total time or begin/end time.
	Start: 07/01/2008
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.
	Start: 07/01/2008
N445	Missing document for actual cost or paid amount.
	Start: 07/01/2008
N446	Incomplete/invalid document for actual cost or paid amount.
	Start: 07/01/2008
N447	Payment is based on a generic equivalent as required documentation was not provided.
	Start: 07/01/2008
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N449	Payment based on a comparable drug/service/supply.
	Start: 07/01/2008
N450	Covered only when performed by the primary treating physician or the designee.
	Start: 07/01/2008
N451	Missing Admission Summary Report.
	Start: 07/01/2008
N452	Incomplete/invalid Admission Summary Report.
	Start: 07/01/2008
N453	Missing Consultation Report.
	Start: 07/01/2008

N454	Incomplete/invalid Consultation Report.
	Start: 07/01/2008
N455	Missing Physician Order.
	Start: 07/01/2008
N456	Incomplete/invalid Physician Order.
	Start: 07/01/2008
N457	Missing Diagnostic Report.
	Start: 07/01/2008
N458	Incomplete/invalid Diagnostic Report.
	Start: 07/01/2008
N459	Missing Discharge Summary.
	Start: 07/01/2008
N460	Incomplete/invalid Discharge Summary.
	Start: 07/01/2008
N461	Missing Nursing Notes.
	Start: 07/01/2008
N462	Incomplete/invalid Nursing Notes.
	Start: 07/01/2008
N463	Missing support data for claim.
	Start: 07/01/2008
N464	Incomplete/invalid support data for claim.
	Start: 07/01/2008
N465	Missing Physical Therapy Notes/Report.
	Start: 07/01/2008
N466	Incomplete/invalid Physical Therapy Notes/Report.
	Start: 07/01/2008
N467	Missing Tests and Analysis Report.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N468	Incomplete/invalid Report of Tests and Analysis Report.
	Start: 07/01/2008
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
	Start: 07/01/2008
N470	This payment will complete the mandatory medical reimbursement limit.
	Start: 07/01/2008
N471	Missing/incomplete/invalid HIPPS Rate Code.
	Start: 07/01/2008
N472	Payment for this service has been issued to another provider.
	Start: 07/01/2008
N473	Missing certification.
	Start: 07/01/2008
N474	Incomplete/invalid certification.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N475	Missing completed referral form.
	Start: 07/01/2008

N476	Incomplete/invalid completed referral form.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N477	Missing Dental Models.
	Start: 07/01/2008
N478	Incomplete/invalid Dental Models.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
	Start: 07/01/2008
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
	Start: 07/01/2008
N481	Missing Models.
	Start: 07/01/2008
N482	Incomplete/invalid Models.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N485	Missing Physical Therapy Certification.
	Start: 07/01/2008
N486	Incomplete/invalid Physical Therapy Certification.
	Start: 07/01/2008
N487	Missing Prosthetics or Orthotics Certification.
	Start: 07/01/2008
N488	Incomplete/invalid Prosthetics or Orthotics Certification.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N489	Missing referral form.
	Start: 07/01/2008
N490	Incomplete/invalid referral form.
	Start: 07/01/2008 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.
	Start: 07/01/2008
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
	Start: 07/01/2008
N493	Missing Doctor First Report of Injury.
	Start: 07/01/2008
N494	Incomplete/invalid Doctor First Report of Injury.
	Start: 07/01/2008
N495	Missing Supplemental Medical Report.
	Start: 07/01/2008
N496	Incomplete/invalid Supplemental Medical Report.
	Start: 07/01/2008
N497	Missing Medical Permanent Impairment or Disability Report.
	Start: 07/01/2008

N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.
	Start: 07/01/2008
N499	Missing Medical Legal Report.
	Start: 07/01/2008
N500	Incomplete/invalid Medical Legal Report.
	Start: 07/01/2008
N501	Missing Vocational Report.
	Start: 07/01/2008
N502	Incomplete/invalid Vocational Report.
	Start: 07/01/2008
N503	Missing Work Status Report.
	Start: 07/01/2008
N504	Incomplete/invalid Work Status Report.
	Start: 07/01/2008
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.
	Start: 11/01/2008
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.
	Start: 11/01/2008
N507	Plan distance requirements have not been met.
	Start: 11/01/2008
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.
	Start: 11/01/2008
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
	Start: 11/01/2008
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
	Start: 11/01/2008
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.
	Start: 11/01/2008
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.
	Start: 11/01/2008
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.
	Start: 11/01/2008
N516	Records indicate a mismatch between the submitted NPI and EIN.
	Start: 03/01/2009
N517	Resubmit a new claim with the requested information.
	Start: 03/01/2009

N518	No separate payment for accessories when furnished for use with oxygen equipment.
	Start: 03/01/2009
N519	Invalid combination of HCPCS modifiers.
	Start: 07/01/2009
N520	Alert: Payment made from a Consumer Spending Account.
	Start: 07/01/2009
N521	Mismatch between the submitted provider information and the provider information stored in our system.
	Start: 11/01/2009
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
	Start: 11/01/2009 | Last Modified: 03/01/2010
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.
	Start: 03/01/2010
N524	Based on policy this payment constitutes payment in full.
	Start: 03/01/2010
N525	These services are not covered when performed within the global period of another service.
	Start: 03/01/2010
N526	Not qualified for recovery based on employer size.
	Start: 03/01/2010
N527	We processed this claim as the primary payer prior to receiving the recovery demand.
	Start: 03/01/2010
N528	Patient is entitled to benefits for Institutional Services only.
	Start: 03/01/2010 | Last Modified: 07/01/2010
	Notes: (Modified 7/1/10)
N529	Patient is entitled to benefits for Professional Services only.
	Start: 03/01/2010 | Last Modified: 07/01/2010
	Notes: (Modified 7/1/10)
N530	Not Qualified for Recovery based on enrollment information.
	Start: 03/01/2010 | Last Modified: 07/01/2010
	Notes: (Modified 7/1/10)
N531	Not qualified for recovery based on direct payment of premium.
	Start: 03/01/2010
N532	Not qualified for recovery based on disability and working status.
	Start: 03/01/2010
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.
	Start: 07/01/2010
N534	This is an individual policy, the employer does not participate in plan sponsorship.
	Start: 07/01/2010
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.
	Start: 07/01/2010
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.
	Start: 07/01/2010
N537	We have examined claims history and no records of the services have been found.
	Start: 07/01/2010

N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
	Start: 07/01/2010
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.
	Start: 07/01/2010
N540	Payment adjusted based on the interrupted stay policy.
	Start: 11/01/2010
N541	Mismatch between the submitted insurance type code and the information stored in our system.
	Start: 11/01/2010
N542	Missing income verification.
	Start: 03/08/2011
N543	Incomplete/invalid income verification.
	Start: 03/08/2011 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future.
	Start: 07/01/2011 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.
	Start: 07/01/2011
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.
	Start: 07/01/2011
N547	A refund request (Frequency Type Code 8) was processed previously.
	Start: 03/06/2012
N548	Alert: Patient's calendar year deductible has been met.
	Start: 03/06/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.
	Start: 03/06/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.
	Start: 03/06/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
	Start: 03/06/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.
	Start: 03/06/2012
N554	Missing/Incomplete/Invalid Family Planning Indicator.
	Start: 07/01/2012 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N555	Missing medication list.
	Start: 07/01/2012
N556	Incomplete/invalid medication list.
	Start: 07/01/2012

N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.
	Start: 07/01/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.
	Start: 07/01/2012
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.
	Start: 07/01/2012
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.
	Start: 11/01/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.
	Start: 11/01/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.
	Start: 11/01/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
	Start: 11/01/2012
	Notes: Related to M39
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.
	Start: 11/01/2012
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed.
	Start: 11/01/2012 | Last Modified: 03/01/2013
	Notes: (Modified 3/1/13)
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.
	Start: 11/01/2012
N567	Not covered when considered preventative.
	Start: 03/01/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
	Start: 03/01/2013
N569	Not covered when performed for the reported diagnosis.
	Start: 03/01/2013
N570	Missing/incomplete/invalid credentialing data.
	Start: 03/01/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N571	Alert: Payment will be issued quarterly by another payer/contractor.
	Start: 03/01/2013
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
	Start: 03/01/2013 | Last Modified: 07/01/2014
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor.
	Start: 03/01/2013

N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
	Start: 07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.
	Start: 07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.
	Start: 07/15/2013
N577	Personal Injury Protection (PIP) Coverage.
	Start: 07/15/2013
N578	Coverages do not apply to this loss.
	Start: 07/15/2013
N579	Medical Payments Coverage (MPC).
	Start: 07/15/2013
N580	Determination based on the provisions of the insurance policy.
	Start: 07/15/2013
N581	Investigation of coverage eligibility is pending.
	Start: 07/15/2013
N582	Benefits suspended pending the patient's cooperation.
	Start: 07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.
	Start: 07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.
	Start: 07/15/2013
N585	Benefits are no longer available based on a final injury settlement.
	Start: 07/15/2013
N586	The injured party does not qualify for benefits.
	Start: 07/15/2013
N587	Policy benefits have been exhausted.
	Start: 07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.
	Start: 07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.
	Start: 07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.
	Start: 07/15/2013
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).
	Start: 07/15/2013
N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.
	Start: 07/15/2013
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).
	Start: 07/15/2013
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.
	Start: 07/15/2013

N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.
	Start: 07/15/2013
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.
	Start: 07/15/2013
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.
	Start: 07/15/2013 | Last Modified: 11/01/2013
N598	Health care policy coverage is primary.
	Start: 07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
	Start: 07/15/2013
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.
	Start: 07/15/2013
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.
	Start: 07/15/2013
N602	Adjusted based on the Redbook maximum allowance.
	Start: 07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.
	Start: 07/15/2013
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.
	Start: 07/15/2013
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.
	Start: 07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.
	Start: 07/15/2013
N607	Service provided for non-compensable condition(s).
	Start: 07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.
	Start: 07/15/2013
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.
	Start: 07/15/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N610	Alert: Payment based on an appropriate level of care.
	Start: 07/15/2013

N611	Claim in litigation. Contact insurer for more information.
	Start: 07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
	Start: 07/15/2013
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.
	Start: 07/15/2013
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).
	Start: 07/15/2013
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
	Start: 07/15/2013
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.
	Start: 07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.
	Start: 07/15/2013
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.
	Start: 07/15/2013
N619	Coverage terminated for non-payment of premium.
	Start: 07/15/2013
N620	Alert: This procedure code is for quality reporting/informational purposes only.
	Start: 07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.
	Start: 07/15/2013
N622	Not covered based on the date of injury/accident.
	Start: 07/15/2013
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
	Start: 07/15/2013
N624	The associated Workers' Compensation claim has been withdrawn.
	Start: 07/15/2013
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.
	Start: 07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.
	Start: 07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
	Start: 07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.
	Start: 07/15/2013
N630	Referral not authorized by attending physician.
	Start: 07/15/2013

N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.
	Start: 07/15/2013
N633	Additional anesthesia time units are not allowed.
	Start: 07/15/2013
N634	The allowance is calculated based on anesthesia time units.
	Start: 07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.
	Start: 07/15/2013
N636	Adjusted because this is reimbursable only once per injury.
	Start: 07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.
	Start: 07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.
	Start: 07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
	Start: 07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.
	Start: 07/15/2013
N641	Reimbursement has been based on the number of body areas rated.
	Start: 07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.
	Start: 07/15/2013
N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.
	Start: 07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.
	Start: 07/15/2013
N645	Mark-up allowance.
	Start: 07/15/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N646	Reimbursement has been adjusted based on the guidelines for an assistant.
	Start: 07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).
	Start: 07/15/2013
N648	Adjusted based on Stop Loss.
	Start: 07/15/2013
N649	Payment based on invoice.
	Start: 07/15/2013
N650	This policy was not in effect for this date of loss. No coverage is available.
	Start: 07/15/2013
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.
	Start: 07/15/2013
N652	The date of service is before the date of loss.
	Start: 07/15/2013
N653	The date of injury does not match the reported date of loss.
	Start: 07/15/2013

N654	Adjusted based on achievement of maximum medical improvement (MMI).
	Start: 07/15/2013
N655	Payment based on provider's geographic region.
	Start: 07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.
	Start: 07/15/2013
N657	This should be billed with the appropriate code for these services.
	Start: 07/15/2013
N658	The billed service(s) are not considered medical expenses.
	Start: 07/15/2013
N659	This item is exempt from sales tax.
	Start: 07/15/2013
N660	Sales tax has been included in the reimbursement.
	Start: 07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.
	Start: 07/15/2013
N662	Alert: Consideration of payment will be made upon receipt of a final bill.
	Start: 07/15/2013
N663	Adjusted based on an agreed amount.
	Start: 07/15/2013
N664	Adjusted based on a legal settlement.
	Start: 07/15/2013
N665	Services by an unlicensed provider are not reimbursable.
	Start: 07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.
	Start: 07/15/2013
N667	Missing prescription.
	Start: 07/15/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N668	Incomplete/invalid prescription.
	Start: 07/15/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N669	Adjusted based on the Medicare fee schedule.
	Start: 07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
	Start: 07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.
	Start: 07/15/2013
N672	Alert: Amount applied to Health Insurance Offset.
	Start: 07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.
	Start: 07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.
	Start: 07/15/2013

N675	Additional information is required from the injured party.
	Start: 07/15/2013
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
	Start: 07/15/2013
N677	Alert: Films/Images will not be returned.
	Start: 11/01/2013
N678	Missing post-operative images/visual field results.
	Start: 11/01/2013
N679	Incomplete/Invalid post-operative images/visual field results.
	Start: 11/01/2013
N680	Missing/Incomplete/Invalid date of previous dental extractions.
	Start: 11/01/2013
N681	Missing/Incomplete/Invalid full arch series.
	Start: 11/01/2013
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.
	Start: 11/01/2013
N683	Missing/Incomplete/Invalid prior treatment documentation.
	Start: 11/01/2013
N684	Payment denied as this is a specialty claim submitted as a general claim.
	Start: 11/01/2013
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
	Start: 11/01/2013
N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.
	Start: 11/01/2013
N687	Alert: This reversal is due to a retroactive disenrollment.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N688	Alert: This reversal is due to a medical or utilization review decision.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N689	Alert: This reversal is due to a retroactive rate change.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N690	Alert: This reversal is due to a provider submitted appeal.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N691	Alert: This reversal is due to a patient submitted appeal.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N693	Alert: This reversal is due to a cancellation of the claim by the provider.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)

N694	Alert: This reversal is due to a resubmission/change to the claim by the provider.
	Start: 11/01/2013
N695	Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudication.
	Start: 11/01/2013
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N698	Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.
	Start: 11/01/2013 | Last Modified: 03/14/2014
	Notes: To be used with claim/service reversal. (Modified 3/14/2014)
N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.
	Start: 03/01/2014
N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.
	Start: 03/01/2014
N701	Payment adjusted based on the Value-based Payment Modifier.
	Start: 03/01/2014
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
	Start: 03/01/2014
N703	This service is incompatible with previously adjudicated claims or claims in process.
	Start: 03/01/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.
	Start: 03/01/2014 | Last Modified: 03/14/2014
	Notes: (Modified 3/14/2014)
N705	Incomplete/invalid documentation.
	Start: 03/01/2014
N706	Missing documentation.
	Start: 03/01/2014
N707	Incomplete/invalid orders.
	Start: 03/01/2014
N708	Missing orders.
	Start: 03/01/2014
N709	Incomplete/invalid notes.
	Start: 03/01/2014
N710	Missing notes.
	Start: 03/01/2014
N711	Incomplete/invalid summary.
	Start: 03/01/2014

N712	Missing summary.
	Start: 03/01/2014
N713	Incomplete/invalid report.
	Start: 03/01/2014
N714	Missing report.
	Start: 03/01/2014
N715	Incomplete/invalid chart.
	Start: 03/01/2014
N716	Missing chart.
	Start: 03/01/2014
N717	Incomplete/Invalid documentation of face-to-face examination.
	Start: 03/01/2014
N718	Missing documentation of face-to-face examination.
	Start: 03/01/2014
N719	Penalty applied based on plan requirements not being met.
	Start: 03/01/2014
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.
	Start: 03/01/2014
N721	This service is only covered when performed as part of a clinical trial.
	Start: 03/01/2014
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.
	Start: 03/01/2014
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.
	Start: 03/01/2014
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.
	Start: 03/01/2014
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
	Start: 03/01/2014
N726	A conditional payment is not allowed.
	Start: 03/01/2014
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
	Start: 03/01/2014
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
	Start: 03/01/2014
N729	Missing patient medical/dental record for this service.
	Start: 11/01/2014
N730	Incomplete/invalid patient medical/dental record for this service.
	Start: 11/01/2014
N731	Incomplete/Invalid mental health assessment.
	Start: 11/01/2014
N732	Services performed at an unlicensed facility are not reimbursable.
	Start: 11/01/2014

N733	Regulatory surcharges are paid directly to the state.
	Start: 11/01/2014
N734	The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.
	Start: 11/01/2014
N735	Adjustment without review of medical/dental record because the requested records were not received or were not received timely.
	Start: 03/01/2015 | Stop: 01/01/2016
N736	Incomplete/invalid Sleep Study Report.
	Start: 03/01/2015
N737	Missing Sleep Study Report.
	Start: 03/01/2015
N738	Incomplete/invalid Vein Study Report.
	Start: 03/01/2015
N739	Missing Vein Study Report.
	Start: 03/01/2015
N740	The member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.
	Start: 03/01/2015
N741	This is a site neutral payment.
	Start: 03/01/2015
N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
	Start: 03/01/2015
N743	Adjusted because the services may be related to an employment accident.
	Start: 03/01/2015
N744	Adjusted because the services may be related to an auto accident.
	Start: 03/01/2015
N745	Missing Ambulance Report.
	Start: 03/01/2015
N746	Incomplete/invalid Ambulance Report.
	Start: 03/01/2015
N747	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.
	Start: 03/01/2015
N748	Adjusted because the related hospital charges have not been received.
	Start: 03/01/2015
N749	Missing Blood Gas Report.
	Start: 03/01/2015
N750	Incomplete/invalid Blood Gas Report.
	Start: 03/01/2015
N751	Adjusted because the drug is covered under a Medicare Part D plan.
	Start: 03/01/2015
N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).
	Start: 03/01/2015
N753	Missing/incomplete/invalid Attachment Control Number.
	Start: 07/01/2015

N754	Missing/incomplete/invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.
	Start: 07/01/2015
N755	Missing/incomplete/invalid ICD Indicator on the 1500 Claim Form.
	Start: 07/01/2015
N756	Missing/incomplete/invalid point of drop-off address.
	Start: 07/01/2015
N757	Adjusted based on the Federal Indian Fees schedule (MLR).
	Start: 07/01/2015
N758	Adjusted based on the prior authorization decision.
	Start: 07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.
	Start: 07/01/2015