ANSI REASON CODES

Reason codes, and the text messages that define those codes, are used to explain why a claim may not have been paid in full. For instance, there are reason codes to indicate that a particular service is never covered by Medicare, that a benefit maximum has been reached, that non-payable charges exceed the fee schedule, or that a psychiatric reduction has been made. Under the standard format, only reason codes approved by the American National Standards Institute (ANSI) Insurance Subcommittee and Medicare-specific supplemental messages approved by CMS may be used.

The ANSI reason codes were designed to replace the large number of different codes used by health payers in this country, and to relieve the burden of medical providers to interpret each of the different coding systems. Although reason codes and CMS message codes will appear in the body of the remittance notice, the text of each code that is used will be printed at the end of the notice to facilitate interpretation. The approximately 10,000 different messages used by Medicare carriers nationwide have been reduced to fewer than 400 messages. The standard messages may expand or change occasionally as the need arises, but CMS plans to limit the frequency of such changes.

Code	Description
01	Deductible amount.
02	Coinsurance amount.
03	Co-payment amount.
04	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
05	The procedure code/bill type is inconsistent with the place of service.
06	The procedure/revenue code is inconsistent with the patient's age.
07	The procedure/revenue code is inconsistent with the patient's gender.
08	The procedure code is inconsistent with the provider type/specialty (taxonomy).
09	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.

Code	Description
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
36	Balance does not exceed co-payment amount.
37	Balance does not exceed deductible.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition.
52	The referring/prescribing provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.

Code	Description
55	Claim/service denied because procedure/ treatment is deemed experimental/ investigational by the payer.
56	Claim/service denied because procedure/ treatment has been deemed "proven to be effective" by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, precertification/ authorization.
63	Correction to a prior claim.
64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood deductible.
67	Lifetime reserve days.
68	DRG weight.
69	Day outlier amount.
70	Cost outlier. Adjustment to compensate for additional costs.
71	Primary payer amount.
72	Coinsurance day.
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days.
78	Non-covered days/Room charge adjustment.
79	Cost report days.
80	Outlier days.
81	Discharges.
82	PIP days.
83	Total visits.
84	Capital Adjustment.
85	Interest amount.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.

Code	Description
91	Dispensing fee adjustment.
92	Claim paid in full.
93	No claim level adjustments.
94	Processed in excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charges.
97	Payment is included in the allowance for another service/procedure.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
99	Medicare Secondary Payer Adjustment amount.
100	Payment made to patient/insured/responsible party.
101	Predetermination. Anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Payment adjusted because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or cancelled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount – not our patient.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
126	Deductible – Major Medical.

Code	Description
127	Coinsurance – Major Medical.
128	Newborn's services are covered in the mother's allowance.
129	Payment denied. Prior processing information appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Claim/Service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement. Subscriber is employed by the provider of the services.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
145	Premium payment withholding.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment.
A8	Claim denied; ungroupable DRG.
B1	Non-covered visits.
B2	Covered visits.
B3	Covered charges.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.

Code	Description
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should not have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patient's medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this service/procedure is not paid separately.
B16	Payment adjusted because "new patient" qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	Claim/service adjusted because of the finding of a Review Organization.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjusted based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength, or dosage of the drug furnished.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that "x-ray is available for review".
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
D10	Claim/service denied. Completed physician financial relationship form not on file.

Code	Description
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
W1	Workers Compensation State Fee Schedule Adjustment.