CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 470 **Date: FEBRUARY 4, 2005**

CHANGE REQUEST 3685

SUBJECT: **Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes and Calculation and Balancing of TS2 and TS3 Segment Data Elements**

I. SUMMARY OF CHANGES: This contains requirements for standardized reporting of group and claim adjustment reason code pairs, and calculation and balancing of TS 3 and TS2 segment data elements reported in Fiscal Intermediary remittance advice and coordination of benefit transactions.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 2005

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - One-Time Notification

Pub. 100-04	Transmittal: 470	Date: February 4, 2005	Change Request 3685

SUBJECT: Standardize use of reason and group codes, and calculation of TS2 and TS3 segment data elements in Fiscal Intermediary (FI) remittance advice and coordination of benefit (COB) transactions.

I. GENERAL INFORMATION

A. Background:

Section A – Uniform and Consistent Use of Group and Claim Adjustment Reason Codes in FI Electronic Remittance Advice (ERA) and Standard Paper Remittance (SPR) Advice Transactions.

Health benefit payers, including Medicare, are limited to use of those internal and external code sets identified in the implementation guides (IG) adopted as standards for national use under the Health Insurance Portability and Accountability Act (HIPAA) when using those transactions. The X12 835 remittance advice and 837 COB IGs require that a group code that assigns financial responsibility for a non-paid amount be reported in conjunction with applicable claim adjustment reason codes that explain why a payment is less or more than the amount billed for a claim or service. Although HIPAA does not apply to paper transactions, CMS requires that SPR transactions that contain fields that correspond to 835 data elements adhere to the same requirements that apply to those 835 data elements. Medicare FIs have reported group and reason codes for many years, but were not previously required to follow uniform guidelines in assignment of group codes to particular reason codes. That policy is being changed by this transmittal.

As part of the continuing effort to foster uniformity among FIs, CMS will now require that FIs report a specific group code in combination with specific reason codes. These group and reason code combinations (attachment) were the product of an FI, FI Shared System (FISS) maintainer, and CMS work group.

If the item and/or service is one for which the financial liability protections in Section 1879 of the Social Security Act (SSA) could apply, the FIs must not indicate in the remittance advice that a beneficiary is liable unless an Advance Beneficiary Notice (ABN) or other notice of non-coverage has been delivered to the beneficiary that properly advises the beneficiary of the reason(s) Medicare will not pay for the item and/or service. See Pub 100-04/30 for more information on these protections. The notification to the beneficiary must be delivered prior to the delivery and billing of the services and may be indicated on claims by the use of codes that indicate a notice was provided. For example, reporting of reason code 50 with group code PR (patient responsibility) on the remittance should reflect: 1) the beneficiary received an ABN, 2) the beneficiary knew that Medicare would not cover the item or service in this particular situation because it was "not reasonable and necessary", 3) the beneficiary requested receipt of the item and/or service, and 4) the beneficiary agreed to pay for the item and/or service if it ultimately was denied coverage by Medicare. If the

provider did not deliver an ABN to a beneficiary for a service that is "not reasonable and necessary", the beneficiary could not be held liable, and group code PR must not be used. Once the item and/or service is denied as “not reasonable and necessary”, the provider would be liable for the item and/or service, and group code CO must be used.

A provider is prohibited from billing a Medicare beneficiary for any adjustment amount identified with a CO group code, but may bill a beneficiary for an adjustment amount identified with a PR group code.

Medicare contractors are permitted to use the following group codes:

CO	Contractual Obligation (provider is financially liable);
CR	Correction and Reversal (no financial liability);
OA	Other Adjustment (no financial liability); and
PR	Patient Responsibility (patient is financially liable).

Although X12 permits use of another group code, PI (payer initiated), with an adjustment reason code, CMS has never permitted Medicare contractors to use this group code as it fails to identify financial liability for the unpaid amount.

The attachment lists each current claim adjustment reason code. The first two columns show the claim adjustment reason code number and the code text. Columns 3-6 contain the four basic types of payment decisions. The last column identifies reason codes that either do not apply to Medicare or have been retired. This attachment will be updated by CMS to a) incorporate new and modified reason codes issued by the committee responsible for claim adjustment reason codes maintenance, and b) if the group/reason code combination needs to be modified for a change in policy or any other reason. Updates to the attachment will be included in the CRs issued by CMS every 4 months to report claim adjustment reason and remark code updates.

The “Not Used” designation was assigned by the eight FI representatives who participated in the work group based upon their experience with use of the codes. This may not reflect the experience of every FI, however. An FI that wishes to use a code identified as “Not Used” that is listed as a valid reason code on the claim adjustment reason code master list maintained at www.wpc-edi.com, must contact Sumita Sen (Ssen@cms.hhs.gov) to explain usage of the code(s) and obtain clearance for continued use. The “Not Used” designation of individual codes may be eliminated in future updates of this chart in the event an FI is able to make a case for usage of a code(s) currently listed as “Not Used.”

Section B – Correct Calculation of TS2 and TS3 Segment Data Elements.

Most of these data elements report totals for categories of data elements reported elsewhere in an 835. Although the X12 835 IG does not specifically require that these totals balance against the applicable individual data elements, CMS now requires that these totals balance. In most cases, the amounts to be included in a TS2 or TS3 data element totals are evident from the applicable semantic note. There has been some FI confusion regarding calculation of the totals for:

TS311 (Total contractual adjustment)—This must equal the sum of all adjustments reported with group code CO in that 835; and

TS317 (Total HCPCS reported charge amount)--This must equal the sum of all reported charge amount(s) reported with qualifier HC in that 835.

The following two tables list the semantic notes from the X12 workbook that apply to these segments and data elements. When reported, these data elements must comply with these semantic notes.

TS3 Segment - Transaction Statistics

01 TS301 is the provider number.
02 TS302 is the facility type code.
03 TS303 is the last day of the provider's fiscal year.
04 TS304 is the total number of claims.
05 TS305 is the total of reported charges.
06 TS306 is the total of covered charges.
07 TS307 is the total of noncovered charges.
08 TS308 is the total of denied charges.
09 TS309 is the total provider payment.
10 TS310 is the total amount of interest paid.
11 TS311 is the total contractual adjustment.
12 TS312 is the total Gramm-Rudman Reduction.
13 TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
14 TS314 is the total blood deductible amount in dollars.
15 TS315 is the summary of non-lab charges.
16 TS316 is the total coinsurance amount.
17 TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
18 TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
19 TS319 is the total deductible amount.
20 TS320 is the total professional component amount.
21 TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
22 TS322 is the total patient reimbursement.
23 TS323 is the total periodic interim payment (PIP) number of claims.
24 TS324 is total periodic interim payment (PIP) adjustment.

TS2 Transaction Supplemental Statistics

01 TS201 is the total diagnosis related group (DRG) amount.

02 TS202 is the total federal specific amount.

03 TS203 is the total hospital specific amount.

04 TS204 is the total disproportionate share amount.

05 TS205 is the total capital amount.

06 TS206 is the total indirect medical education amount.

07 TS207 is the total number of outlier days.

08 TS208 is the total day outlier amount.

09 TS209 is the total cost outlier amount.

10 TS210 is the diagnosis related group (DRG) average length of stay.

11 TS211 is the total number of discharges.

12 TS212 is the total number of cost report days.

13 TS213 is the total number of covered days.

14 TS214 is total number of non-covered days.

15 TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.

16 TS216 is the average diagnosis-related group (DRG) weight.

17 TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.

18 TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.

19 TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

B. Policy: CMS requires that the totals in TS3 and TS2 data elements balance against the applicable individual data elements reported in a FI 835 that apply to that category of data element. CMS requires that specific group codes be reported with specific claim adjustment reason codes when included in 835, SPR or COB transactions.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
						FISS	MCS	VMS	CWF	
3685.1	**Section A:** By July 5, 2005, FIs and RHHIs shall use the combination of group and reason code as listed in the attachment.	X	X			X				
3685.2	**Section B:** By July 5, 2005, FISS shall make necessary programming changes to calculate and populate the TS2/TS3 fields per the X12 segment notes listed above. Any total in these fields must reconcile with the sum of that variable inserted in other relevant segment(s).					X				

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Sumita Sen, ssen@cms.hhs.gov 410-786-5755 **Post-Implementation Contact(s):** Sumita Sen, ssen@cms.hhs.gov 410-786-5755	**These instructions shall be implemented within your current operating budget.**

REASON CODE INVENTORY

NOTE: Although not listed in the spreadsheet, group code CR may apply to any reason code for correction and reversal

Code #	Code Description	Contractual Adj	Denied	Non Covered	Other	Not Used
1	Deductible Amount				PR	
2	Coinsurance Amount				PR	
3	Co-payment Amount				PR	
4	The procedure code is inconsistent with the modifier used or a required		CO			
	modifier is missing.					
5	The procedure code/bill type is inconsistent with the place of service.		CO			
6	The procedure/revenue code is inconsistent with the patient's age.		CO			
7	The procedure/revenue code is inconsistent with the patient's gender.		CO			
8	The procedure code is inconsistent with the provider type/specialty		CO			
	(taxonomy).					
9	The diagnosis is inconsistent with the patient's age.		CO			
10	The diagnosis is inconsistent with the patient's gender.		CO			
11	The diagnosis is inconsistent with the procedure.		CO			
12	The diagnosis is inconsistent with the provider type.		CO			
13	The date of death precedes the date of service.		CO			
14	The date of birth follows the date of service.		CO			
15	Payment adjusted because the submitted authorization number is missing,					X
	invalid, or does not apply to the billed services or provider.					
16	Claim/service lacks information which is needed for adjudication. Additional		CO			
	information is supplied using remittance advice remarks codes					
	whenever appropriate.					
17	Payment adjusted because requested information was not provided or was		CO			
	insufficient/incomplete. Additional information is supplied using the					
	remittance advice remarks codes whenever appropriate.					
18	Duplicate claim/service.		CO			
19	Claim denied because this is a work-related injury/illness and thus the		CO			
	liability of the Worker's Compensation Carrier.					
20	Claim denied because this injury/illness is covered by the liability carrier.		CO			
21	Claim denied because this injury/illness is the liability of the no-fault carrier.		CO			
22	Payment adjusted because this care may be covered by another payer per		CO			
	coordination of benefits.					
23	Payment adjusted because charges have been paid by another payer.			OA		
24	Payment for charges adjusted. Charges are covered under a capitation		CO			
	agreement/managed care plan.					
25	Payment denied. Your Stop loss deductible has not been met.					X
26	Expenses incurred prior to coverage.			PR		
27	Expenses incurred after coverage terminated.			PR		
28	Coverage not in effect at the time the service was provided.					X
29	The time limit for filing has expired.	CO				
30	Payment adjusted because the patient has not met the required eligibility,			PR		
	spend down, waiting, or residency requirements.					
31	Claim denied as patient cannot be identified as our insured.			PR		
32	Our records indicate that this dependent is not an eligible dependent as					X
	defined.					
33	Claim denied. Insured has no dependent coverage.					X
34	Claim denied. Insured has no coverage for newborns.					X
35	Lifetime benefit maximum has been reached.			PR		
36	Balance does not exceed co-payment amount.					X
37	Balance does not exceed deductible.					X
38	Services not provided or authorized by designated (network/primary care)			PR		
	providers.					
39	Services denied at the time authorization/pre-certification was requested.					X
40	Charges do not meet qualifications for emergent/urgent care.					X
41	Discount agreed to in Preferred Provider contract.					X
42	Charges exceed our fee schedule or maximum allowable amount.	CO				
43	Gramm-Rudman reduction.					X
44	Prompt-pay discount.					X
45	Charges exceed your contracted/ legislated fee arrangement.	CO				
46	This (these) service(s) is (are) not covered.					X
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.		CO/PR			
48	This (these) procedure(s) is (are) not covered.					X
49	These are non-covered services because this is a routine exam or screening		PR			
	procedure done in conjunction with a routine exam.					
50	These are non-covered services because this is not deemed a `medical		CO/PR			
	necessity' by the payer.					
51	These are non-covered services because this is a pre-existing condition					X
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/					X
	order/perform the service billed.					
53	Services by an immediate relative or a member of the same household are					X

REASON CODE INVENTORY

NOTE: Although not listed in the spreadsheet, group code CR may apply to any reason code for correction and reversal

Code #	Code Description	Contractual Adj	Denied	Non Covered	Other	Not Used
	not covered.					
54	Multiple physicians/assistants are not covered in this case .					X
55	Claim/service denied because procedure/treatment is deemed experimental/		CO/PR			
	investigational by the payer.					
56	Claim/service denied because procedure/treatment has not been deemed					X
	`proven to be effective' by the payer.					
57	Payment denied/reduced because the payer deems the information					X
	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		CO/PR			
	been rendered in an inappropriate or invalid place of service.					
59	Charges are adjusted based on multiple surgery rules or concurrent					X
	anesthesia rules.					
60	Charges for outpatient services with this proximity to inpatient services are		CO			
	not covered.					
61	Charges adjusted as penalty for failure to obtain second surgical opinion.					X
62	Payment denied/reduced for absence of, or exceeded,					X
	pre-certification/authorization.					
63	Correction to a prior claim.					X
64	Denial reversed per Medical Review.					X
65	Procedure code was incorrect. This payment reflects the correct code.					X
66	Blood Deductible.				PR (Sys Assign)	
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)					X
68	DRG weight. (Handled in CLP12)					X
69	Day outlier amount.					X
70	Cost outlier - Adjustment to compensate for additonal costs.	CO				
71	Primary Payer amount.					X
72	Coinsurance day. (Handled in QTY, QTY01=CD)					X
73	Administrative days.					X
74	Indirect Medical Education Adjustment.					X
75	Direct Medical Education Adjustment.					X
76	Disproportionate Share Adjustment.					X
77	Covered days. (Handled in QTY, QTY01=CA)					X
78	Non-Covered days/Room charge adjustment.					X
79	Cost Report days. (Handled in MIA15)					X
80	Outlier days. (Handled in QTY, QTY01=OU)					X
81	Discharges.					X
82	PIP days.					X
83	Total visits.					X
84	Capital Adjustment. (Handled in MIA)					X
85	Interest amount.					X
86	Statutory Adjustment.					X
87	Transfer amount.					X
88	Adjustment amount represents collection against receivable created in prior					X
	overpayment.					
89	Professional fees removed from charges.					X
90	Ingredient cost adjustment.					X
91	Dispensing fee adjustment.					X
92	Claim Paid in full.					X
93	No Claim level Adjustments.					X
94	Processed in Excess of charges.	CO				
95	Benefits adjusted. Plan procedures not followed.					X
96	Non-covered charge(s).			CO/PR		
97	Payment is included in the allowance for another service/procedure.	CO				
98	The hospital must file the Medicare claim for this inpatient non-physician					X
	service.					
99	Medicare Secondary Payer Adjustment Amount.					X
100	Payment made to patient/insured/responsible party.					
101	Predetermination: anticipated payment upon completion of services or claim					X
	adjudication.					
102	Major Medical Adjustment.					X
103	Provider promotional discount (e.g., Senior citizen discount).					X
104	Managed care withholding.					X
105	Tax withholding.					X
106	Patient payment option/election not in effect.					X
107	Claim/service denied because the related or qualifying claim/service was not		CO/PR			
	previously paid or identified on this claim.					
108	Payment adjusted because rent/purchase guidelines were not met.					X
109	Claim not covered by this payer/contractor. You must send the claim to the		CO			

REASON CODE INVENTORY

NOTE: Although not listed in the spreadsheet, group code CR may apply to any reason code for correction and reversal

Code #	Code Description	Contractual Adj	Denied	Non Covered	Other	Not Used
	correct payer/contractor.					
110	Billing date predates service date.		CO			
111	Not covered unless the provider accepts assignment.					X
112	Payment adjusted as not furnished directly to the patient and/or not		CO			
	documented.					
113	Payment denied because service/procedure was provided outside the United					X
	States or as a result of war.					
114	Procedure/product not approved by the Food and Drug Administration.		CO			
115	Payment adjusted as procedure postponed or canceled.		OA			
116	Payment denied. The advance indemnification notice signed by the patient		CO			
	did not comply with requirements.					
117	Payment adjusted because transportation is only covered to the closest			CO/PR		
	facility that can provide the necessary care.					
118	Charges reduced for ESRD network support.	CO				
119	Benefit maximum for this time period has been reached.		CO/PR			
120	Patient is covered by a managed care plan.					X
121	Indemnification adjustment.					X
122	Psychiatric reduction.		PR			
123	Payer refund due to overpayment.					X
124	Payer refund amount - not our patient.					X
125	Payment adjusted due to a submission/billing error(s). Additional information		CO			
	is supplied using the remittance advice remarks codes whenever appropriate.					
126	Deductible -- Major Medical					X
127	Coinsurance -- Major Medical					X
128	Newborn's services are covered in the mother's Allowance.					X
129	Payment denied - Prior processing information appears incorrect.					X
130	Claim submission fee.					X
131	Claim specific negotiated discount.					X
132	Prearranged demonstration project adjustment.					X
133	The disposition of this claim/service is pending further review.					X
134	Technical fees removed from charges.					X
135	Claim denied. Interim bills cannot be processed.					X
136	Claim Adjusted. Plan procedures of a prior payer were not followed.					X
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances					X
	or Health Related Taxes.					
138	Claim/service denied. Appeal procedures not followed or time limits not met.					X
139	Contracted funding agreement - Subscriber is employed by the provider of					X
	services.					
140	Patient/Insured health identification number and name do not match.					X
141	Claim adjustment because the claim spans eligible and ineligible periods of					X
	coverage.					
142	Claim adjusted by the monthly Medicaid patient liability amount.					X
143	Portion of payment deferred.					X
144	Incentive adjustment, e.g. preferred product/service.					X
145	Premium payment withholding					X
146	Payment denied because the diagnosis was invalid for the date(s) of service					X
	reported.					X
147	Provider contracted/negotiated rate expired or not on file.					X
148	Claim/service rejected at this time because information from another					X
	provider was not provided or was insufficient/incomplete.					
149	Lifetime benefit maximum has been reached for this service/benefit category.					X
150	Payment adjusted because the payer deems the information submitted		CO			
	does not support this level of service.					
151	Payment adjusted because the payer deems the information submitted does		CO			
	not support this many services.					
152	Payment adjusted because the payer deems the information submitted does		CO			
	not support this length of service.					
153	Payment adjusted because the payer deems the information submitted does		CO			
	not support this dosage.					
154	Payment adjusted because the payer deems the information submitted		CO			
	does not support this day's supply.					
155	This claim is denied because the patient refused the service/procedure.					X
156	Flexible spending account payments					X
157	Payment denied/reduced because service/procedure was provided as a					X
	result of an act of war.					
158	Payment denied/reduced because the service/procedure was provided					X
	outside of the United States.					
159	Payment denied/reduced because the service/procedure was provided as a					X
	result of terrorism.					

REASON CODE INVENTORY

NOTE: Although not listed in the spreadsheet, group code CR may apply to any reason code for correction and reversal

Code #	Code Description	Contractual Adj	Denied	Non Covered	Other	Not Used
160	Payment denied/reduced because injury/illness was the result of an activity					X
	that is a benefit exclusion.					
161	Provider performance bonus					X
162	State-mandated Requirement for Property and Casualty; see Claim					X
	Payment Remark Code for Specific Explanation.					
163	Claim/Service adjusted because the attachment referenced on the claim					X
	was not received.					
164	Claim/Service adjusted because the attachment referenced on the claim					X
	was not received in a timely fashion.					
165	Payment denied/reduced for absence of, or exceeded referral.					X
A0	Patient refund amount.	CO				
A1	Claim denied charges.		CO/PR			
A2	Contractual adjustment.					X
A3	Medicare Secondary Payer liability met.					X
A4	Medicare Claim PPS Capital Day Outlier Amount.					X
A5	Medicare Claim PPS Capital Cost Outlier Amount.					X
A6	Prior hospitalization or 30 day transfer requirement not met.		CO/PR			
A7	Presumptive Payment Adjustment				OA	
A8	Claim denied; ungroupable DRG					X
B1	Non-covered visits.		CO			
B2	Covered visits.					X
B3	Covered charges.					X
B4	Late filing penalty.					X
B5	Payment adjusted because coverage/program guidelines were not met or	CO/PR/OA	PR/OA	CO/PR/OA		
	were exceeded.					
B6	This payment is adjusted when performed/billed by this type of provider, by	CO	PR/OA			
	this type of provider in this type of facility, or by a provider of this specialty.					
B7	This provider was not certified/eligible to be paid for this procedure/service		CO			
	on this date of service.					
B8	Claim/service not covered/reduced because alternative services were		CO/PR			
	available, and should have been utilized.					
B9	Services not covered because the patient is enrolled in a Hospice.		CO/PR			
B10	Allowed amount has been reduced because a component of the basic		CO			
	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					X
	processing. Claim/service not covered by this payer/processor.					
B12	Services not documented in patients' medical records.		CO			
B13	Previously paid. Payment for this claim/service may have been provided in a		CO			
	previous payment.					
B14	Payment denied because only one visit or consultation per physician per					X
	day is covered.					
B15	Payment adjusted because this procedure/service is not paid separately.	CO	CO/PR	CO/PR/OA		
B16	Payment adjusted because `New Patient' qualifications were not met.		CO			
B17	Payment adjusted because this service was not prescribed by a physician,		CO			
	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		CO			
	date of service or claim submission.					
B19	Claim/service adjusted because of the finding of a Review Organization.					X
B20	Payment adjusted because procedure/service was partially or fully furnished		CO			
	by another provider.					
B21	The charges were reduced because the service/care was partially furnished					X
	by another physician.					
B22	This payment is adjused based on the diagnosis.		CO			
B23	Payment denied because this provider has failed an aspect of a proficiency					X
	testing program.					
D1	Claim/service denied. Level of subluxation is missing or inadequate.					X
D2	Claim lacks the name, strength, or dosage of the drug furnished.					X
D3	Claim/service denied because information to indicate if the patient owns the					X
	equipment that requires the part or supply was missing.					
D4	Claim/service does not indicate the period of time for which this will be					X
	needed.					
D5	Claim/service denied. Claim lacks individual lab codes included in the test.					X
D6	Claim/service denied. Claim did not include patient's medical record for the					X
	service.					
D7	Claim/service denied. Claim lacks date of patient's most recent physician					X
	visit.					
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review.'					X

REASON CODE INVENTORY

NOTE: Although not listed in the spreadsheet, group code CR may apply to any reason code for correction and reversal

Code #	Code Description	Contractual Adj	Denied	Non Covered	Other	Not Used
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual					X
	cost of the lens, less discounts or the type of intraocular lens used.					
D10	Claim/service denied. Completed physician financial relationship form not					X
	on file.					
D11	Claim lacks completed pacemaker registration form.					X
D12	Claim/service denied. Claim does not identify who performed the purchased					X
	diagnostic test or the amount you were charged for the test.					
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/					X
	referring physician has a financial interest.					
D14	Claim lacks indication that plan of treatment is on file.					X
D15	Claim lacks indication that service was supervised or evaluated by a					X
	physician.					
D16	Claim lacks prior payer payment information.					X
D17	Claim/Service has invalid non-covered days.					X
D18	Claim/Service has missing diagnosis information.		CO			
D19	Claim/Service lacks Physician/Operative or other supporting documentation.		CO			
D20	Claim/Service missing service/product information.		CO			
W1	Workers Compensation State Fee Schedule Adjustment					X