RESOURCE AND PATIENT MANAGEMENT SYSTEM

Accounts Receivable

(BAR)

Addendum to User Manual

Version 1.8 Patch 24
June 2014

Office of Information Technology
Division of Information Technology
Albuquerque, New Mexico

Table of Contents

Preface

The Accounts Receivable application automates the management of accounts receivables in the Indian Health Service (IHS) Resource and Patient Management System (RPMS) including:

- The setup of sites to function in a parent/satellite relationship and effectively handle collection, billing, posting, and reporting activities.
- Automating the reporting process to the federal financial reporting system.

This document provides information on the updates that have been released for the application and should be distributed and reviewed with the Revenue Generation field staff and Area Office support, preferably prior to the installation of the patch.

New Standard Adjustment Reason (SAR) codes have been added. Some SAR codes may have required new or additional Adjustment Types to be added which may have an impact on the electronic and manual posting processes. See Appendix A for a complete list of codes.

1.0 Summary of Changes

Patch 24 provides enhancements and minor corrections to v1.8 of the Accounts Receivable application. It includes the following fixes and changes for reported issues logged at the RPMS Helpdesk:

Collections Entry

- **HEAT148839** – A correction was made to Collections Entry (BAR > COL > EN) to prevent an undefined error at Tribal sites that are using the TDN/IPAC functionality for batching checks. <UNDEFINED>GO+7^DIE

Electronic Remittance Advice

- **HEAT147572** – Changes were made to the Electronic Remittance Advice (ERA) to accommodate non-Federal locations (Tribes/Urban/638/etc.) who wish to turn off ERA posting restrictions that were put in place to comply with Unified Financial Management System (UFMS) reporting requirements for Federal locations. These restrictions prevent the ERA from posting to a cancelled bill, posting a transaction that will create a negative bill balance, and posting a transaction that will create a negative collection batch/item balance.
- **HEAT147789** – Update to the Standard Adjustment Reason Codes. Upon patch installation, the A/R EDI STND CLAIM ADJ REASONS file will be automatically updated with the latest codes. A complete list of Standard Adjustment Reason codes can be found in the Appendix of this document.
- **HEAT148388** – A fix was provided to the ERA to recognize a reverse payment in an ERA file when paired with a claim status code of 1 (processed as primary). Previously the ERA only recognized a reverse payment when paired with a claim status code of 22 (reverse payment).
- **HEAT148835** – The following message was removed from the A/R Bill Matching option (BLMT): ***THE MATCHING PROCESS FOUND SEVERAL UNMATCHED CLAIMS *** YOU CAN PRINT NOW A REPORT WITH MORE DETAILS.
- **HEAT151948** – A change was made to prevent the ERA from calculating the following Adjustment Categories into a bill's balance: General Information and Pending. These two Adjustment Categories are informational only and do not affect the bill balance.
- **HEAT152930** – A correction was made to a message that's displayed in the Review & Match File for BPR option (BPR) when a potential duplicate Collection Batch/Item has been found so that the data displayed in a user-friendly format, rather than a FileMan format.

- **NOHEAT2** – A change was made to accommodate payers who send a zero in the bill number segment of an ERA file (CLP01), rather than a valid bill number. The bill will be marked with the following Reason Not to Post in the REV option: RA CLAIM NOT FOUND IN RPMS. Users may manually match these ERA claims with a valid RPMS bill number by using the Edit Status command in the REV option, if applicable.
- **NOHEAT3 -** A correction was made to the Load New Import (NEW) option to accept and store dates in the CLAIM RECEIVED DATE segment of an ERA file that are not already in a FileMan format. This will prevent ?? from being displayed after the ERA claim number during the Load New Import process.

Manual Posting

- **HEAT146880** – A new Adjustment Type named "Cancelled/Expired Appropriation" was added under the General Information adjustment category.
- **HEAT148695** – A modification was made to the Select Command prompt in the following posting options to prevent invalid entries from being entered: Post Status Change (ACM > PSC), Post Payments and Adjustments (PST > PAY), Post Adjustments (PST > ADJ), and Flat Rate Posting (PST > FRP).
- **NOHEAT1** – A correction was made to the Select Command prompt in the posting options listed in the previous item so that the system will not return a programmer error if a key is pressed for an extended amount of time.

Patient Statements

- **HEAT100207** – A correction was made to patient statements to prevent insurance amounts due from being included in the aging summary.
- **HEAT144442** – A correction was made to patient statements to allow the user to exit with '^' when printing statements to the computer screen.
- **HEAT152220** – A correction was made to the Print One Flagged Patient's Account Statement option to prevent a statement variable from being undefined.

Debt Letters

- **HEAT143490** – A correction was made to debt letters so that the greeting of the letter is addressed to the payer rather than "To the Guardian of".
- **HEAT152452** – A correction was made to debt letters to prevent a subscript error when users access the debt letter menus before the A/R application has been completely set up. Instead of a subscript error, the following message will be displayed: (FACILITY NAME) HAS NOT BEEN REGIONALLY SETUP. CONTACT YOUR A/R MANAGER.

Reports

- **HEAT114352** – A new report called Non-Ben Payment Report was added to the Financial Reports menu. This report was designed to provide payment information for non-beneficiary patients and includes the following: bill number, amount billed, insurance payment amount, patient payment amount and date posted, and remaining balance due.
- **HEAT124730** – The bill date of service was added to the Batch Posted Payments report and to the Transaction Statistical Report.
- **HEAT132196** – A correction was made to the Age Summary Report to prevent a syntax error when a bill is found that is missing the A/R Account. <SYNTAX>DATA+60^BARRASM
- **HEAT141692** – The A/R Bill and Transaction Statistical Report was modified so that the Type of Report defaults to detail rather than summary.
- **HEAT143222** – A correction was made to the Top Payer Report to prevent an undefined error when the user types '^' to exit the report at the Sort parameter. <UNDEFINED>HDRSORT+2^BARRPAY
- **HEAT148395** – A correction was made to the A/R Statistical Report so that the user-specified billing entity is correctly reflected in the report header.
- **HEAT150941** – A correction was made to the Inpatient Primary Diagnosis report so that the diagnosis parameter is not a required selection. The following selections were also removed from the diagnosis parameter in the Inpatient Primary Diagnosis report and the Top Payer Report: Search in Primary Diagnosis Only, and All Diagnosis.
- **HEAT151319** – A correction was made to the Bills Listing Report to prevent zero balance bills from dropping off the report. All bills that fall into the user-specified parameters should be reported, regardless of bill balance.
- **HEAT153046** – A correction was made to the Transaction Statistical Report so report totals are being calculated correctly in the Transaction Amount column.

Other Changes

- **HEAT118656** – Several changes were made to the following two options to provide more detail when uploading bills manually from Third Party Billing: Upload from Third Party Bill File and Upload Third Party Bills by Approval Dates.
- **HEAT147266** – A correction was made to BARMAWO to correctly recognize the user-specified date range.

2.0 Patch 24

2.1 Uploading Bills from Third Party Billing

BAR > UPL
BAR > MAN > UPAP

The upload options were modified to provide greater detail to the bill posting history; however, some of these modifications are dependent on changes to Third Party Billing (TPB) that will be released in a later TPB patch. Without those changes to TPB, both upload options will create an entry in the A/R Bill file and will create one third party (3P) credit transaction for the following transaction types that were previously rolled back to TPB:

- Payments
- Co-payment adjustments
- Deductible adjustments.

In Figure 2-1 a 3P credit adjustment of $60.00 was created by the upload, which reflects a payment of $50.00 and a co-payment adjustment of $10 that were both rolled back to Third Party Billing as part of the posting process.

```
              List of Transactions for Bill 31294A-IH-100214

Patient: PATIENT,PRIVATE                      Beg DOS : JAN 20, 2014
Address: 100 DEMO LANE                        End DOS : JAN 20, 2014
SOMEWHERE, USA 12345                          LST STMT:

Phone #: 505-555-5555                         Insurer: BCBS OF NEW MEXICO
                                              Balance: 30.00

Trans Dt   By  Trans Type                                 Amount       Balance
               A/R Account                Batch                    Item
-------------------------------------------------------------------------------
04/01/2014     BILL NEW                                     90.00        90.00
               BCBS OF NEW MEXICO (FEP)   NO BATCH                  0
04/01/2014     3P CREDIT                                   (60.00)       30.00
               BCBS OF NEW MEXICO (FEP)   NO BATCH                  0
```

Figure 2-1: Example of how the upload options currently create transactions in A/R.

Once the necessary changes have been released in a TPB patch, the upload options will create an individual transaction in A/R for each payment and adjustment that was rolled back to TPB as part of the posting process.

In Figure 2-2, three transactions were created by the upload in addition to the bill new transaction: one for the co-pay, one for a non-payment, and one for the payment (indicated as a Payment Credit adjustment).

```
                  List of Transactions for Bill 31294A-IH-100214

Patient: PATIENT,PRIVATE                      Beg DOS : JAN 20, 2014
Address: 100 DEMO STREET                      End DOS : JAN 20, 2014
SOMEWHERE, USA 12345                          LST STMT:

Phone #: 505-555-5555                         Insurer: BCBS OF NEW MEXICO
                                              Balance: 0.00

Trans Dt   By  Trans Type                                  Amount       Balance
               A/R Account                  Batch                    Item
-------------------------------------------------------------------------------
12/02/2013     BILL NEW                                     52.48        52.48
               PRIME THERAPEUTICS-RX        NO BATCH                0
12/02/2013     CO-PAY/                                    (27.11)       25.37
               PRIME THERAPEUTICS-RX        NO BATCH                0
12/02/2013     NON PAYMENT/                               (13.26)       12.11
               PRIME THERAPEUTICS-RX        NO BATCH                0
12/02/2013     PAYMENT CREDIT/                            (12.11)        0.00
               PRIME THERAPEUTICS-RX        NO BATCH                0
```

Figure 2-2: Example of transactions created by upload options after updates have been released by TPB.

2.2 Standard Adjustment Reason Codes Updated

BAR > PST

With the installation of p24, the most recent updates to Claim Adjustment Reason Codes will be added to the A/R EDI STND CLAIM ADJ REASONS file. These codes are used by the Electronic Remittance Advice posting option, but can also be utilized via the RPMS manual posting options (PAY, ADJ, etc.). To view any of the Claim Adjustment Reason Codes in RPMS, enter the number of the adjustment code from the SAR Code column of the list in Appendix A.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p24          |
          +           Standard Adjustment Reason Inquiry            +
          |                INDIAN HEALTH HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: CARLTON,GINA            BUSINESS OFFICE     3-APR-2014 11:34 AM

NOTE:  For a complete hardcopy listing of Standard Adjustment Reason Codes,
       please refer to the User Manual.

Standard Adjustment Reason Code: 248

Output DEVICE: HOME//   Virtual

================================================================================
Standard Adjustment Reason Code Inquiry          APR 3,2014@11:34   Page 1
================================================================================

STANDARD                SHORT Coins for Prof svc rendered in
    CODE: 248           DESC: Institutional setting and billed on Instclm.
```

```
    RPMS  14            RPMS    988
CATEGORY: CO-PAY        REASON: Coins-Prof svc rendrd in Inst

FULL STANDARD CODE DESCRIPTION:

     Coinsurance for Professional service rendered in an Institutional
     setting and billed on an Institutional claim.
```

Figure 2-3: Example of viewing a SAR code in the IADJ option.

The following is a list of new SAR codes that have been added to A/R with the installation of p24. Appendix A contains the complete list of SAR codes .

SAR Code	Long Description	Adj-Cat Code	Adjust Category	RPMS Adj-Reason Code	Adjustment Reason
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	Non Payment	980	Dx inconsist w pt's birth wt
241	Low Income Subsidy (LIS) Co-payment Amount	14	Co-pay	981	Low Income Subsidy copay amt
242	Services not provided by network/primary care providers.	4	Non Payment	982	Svcs not provided by netwk/pcp
243	Services not authorized by network/primary care providers.	4	Non Payment	983	Svcs not auth'd by network/pcp
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	21	Pending	984	Pmt reduced to zero due to lit
245	Provider performance program withhold.	15	Penalty	985	Prov performance prog withhold
246	This non-payable code is for required reporting only.	4	Non Payment	986	Non-payable code for req'd rep
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	13	Deductible	987	Ded-Prof svc rendered in Inst
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	14	Co-pay	988	Coins-Prof svc rendrd in Inst
249	This claim has been identified as a readmission. (Use only with Group Code CO).	4	Non Payment	989	Clm identified as readmission

SAR Code	Long Description	Adj-Cat Code	Adjust Category	RPMS Adj-Reason Code	Adjustment Reason
250	The attachment/other documentation content received is inconsistent with the expected content.	4	Non Payment	300	Doc rcvd inconsist w/exp cntnt
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	4	Non Payment	301	Doc rcvd not contain req cntnt
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.	4	Non Payment	302	Doc reqd to adjudicate clm/svc
253	Sequestration - reduction in federal payment	15	Penalty	303	Sequestration -red in fed pymt
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	4	Non Payment	304	Submit svcs to pt's med plan
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	21	Pending	305	Clm pending due to litigation
256	Service not payable per managed care contract.	4	Non Payment	306	Not payable per mngd care cont
257	The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)	21	pending	307	Clm pndng during prem grace pd
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	4	Non Payment	308	Clm not cvrd - pt incarcerated
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	22	General Information	401	ST-mandated rqrmt for property
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. To be used for Workers' Compensation only.	4	Non Payment	402	Not work related inj/illness
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only.	4	Non Payment	403	WC case settled, pt resp

SAR Code	Long Description	Adj-Cat Code	Adjust Category	RPMS Adj-Reason Code	Adjustment Reason
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. To be used for Workers' Compensation only.	4	Non Payment	404	WC case adjudicated as non-WC
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	4	Non Payment	405	Based on payer reas & cust fee
P6	Based on entitlement to benefits. To be used for Property and Casualty only.	4	Non Payment	406	Based on entitlement to bnfts
P7	The applicable fee schedule/database doesn't contain the billed code. Resubmit bill with appropriate fee schedule/database code(s) that best describe service(s) provided and supporting documents if req.	22	General Information	407	Resub w/correct proc code
P8	Claim is under investigation. To be used for Property and Casualty only.	22	General Information	408	Clm is under investigation
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	4	Non Payment	409	No CPT/HCPCS to describe svc
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	4	Non Payment	410	Zero pmt due to litigation
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	21	Pending	411	Clm pending due to litigation
P12	Workers' compensation jurisdictional fee schedule adjustment. To be used for Workers' Compensation only.	4	Non Payment	412	WC fee schedule adjustment
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Workers' Compensation only.	4	Non Payment	413	Pmt reduced due to WC policies
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. To be used for Property and Casualty only.	4	Non Payment	414	Pmt incl w/pmt for other svc

SAR Code	Long Description	Adj-Cat Code	Adjust Category	RPMS Adj-Reason Code	Adjustment Reason
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	4	Non Payment	415	WC Med Trtmt Guideline adjstmt
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	4	Non Payment	416	Med prov not auth'd for WC
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	15	Penalty	417	Referral not auth'd by attndng
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	4	Non Payment	418	Proc not listed/comp svc allwd
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	4	Non Payment	419	No pymt due,proc fee is zero
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	4	Non Payment	420	Svc not pd under oupt fee schd
P21	Pymnt den based on Med Pymnts Coverage or Personal Inj Protection Ben jurisdictional regulations or payment policies, use only if no other code applicable. Used for Property & Casualty Auto only.	4	Non Payment	421	TPL Payment denied-MPC/PIP
P22	Pymnt adjust based on Medical Pymnts Cov or Personal Injury Protection Ben jurisdictional regulations or pymnt policies, use only if no other code is app. Used for Property and Casualty Auto only.	4	Non Payment	422	TPL Payment adjusted-MPC/PIP
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.	4	Non Payment	423	TPL Fee Sch Adjust-MPC/PIP
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. For use by Property and Casualty only.	4	Non Payment	823	Pmt incl w/pmt for other svc

SAR Code	Long Description	Adj-Cat Code	Adjust Category	RPMS Adj-Reason Code	Adjustment Reason
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	4	Non Payment	824	WC Med Trtmt Guideline adjstmt
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	4	Non Payment	825	Med prov not auth'd for WC
W6	Referral not authorized by attending physician per regulatory requirement.	15	Penalty	826	Referral not auth'd by attndng
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	22	General Information	827	Proc not listed/comp svc allwd
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	22	General Information	828	No pymt due,proc fee is zero
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	4	Non Payment	829	Svc not pd under oupt fee schd
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	4	Non Payment	841	Payment denied
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	4	Non Payment	842	Payment adjusted
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment.	22	General Information	843	Fee schedule adjustment

Figure 2-4: List of new SAR codes included in p24.

2.3 Cancelled/Expired Appropriations Adjustment Type

BAR > PST

A new adjustment type called Cancelled/Expired Appropriation was added under the General Information adjustment category. This code will be used by Federal locations once a location has eliminated all balances for fiscal years that are expired or cancelled.

The concept is this: once a fiscal year's balance reaches a certain age (5 years), any collections received on open balances can no longer be applied through RPMS. These open balances should be eliminated in RPMS and in UFMS with the appropriate adjustment code.

The new Cancelled/Expired Appropriations adjustment type should also be applied to these open balances in RPMS for audit trail purposes. A transaction will not be sent to UFMS for this new General Information code. Contact your area finance department for detailed instructions on dealing with cancelled and expired appropriations.

```
Claims for PATIENT,DEMO     from 03/03/2014 to 03/03/2014       Page: 1

Batch  :  NON-BEN          Item   : 1
Amount :  1329.23          Amount :  1305.47
Posted :     0.00          Posted :     0.00
Unalloc:     0.00          Unalloc:     0.00
Balance:  1329.23          Balance:  1305.47

                                     Billed    Current    Current    Current
Line #  DOS       Claim #            Amount    Paymnts     Adjust    Balance
-------------------------------------------------------------------------------
  1   03/03/2014  31301A-IH-130214   283.00     0.00       0.00     164.21

Select Command (Line # 1) : A
Adjustment Amount: 164.21
Adjustment Category: GENERAL INFORMATION       GENINF
Adjustment Type: ??

   Choose from:
   400          Cancelled/Expired Appropriation
   401          ST-mandated rqrmt for property
   407          Resub w/correct proc code
   408          Clm is under investigation
```

Figure 2-5: Example of new General Information code from within the PAY option.

2.4 ERA Changes for non-IHS Facilities

> **Note:** This section pertains only to non-IHS facilities (Tribes, Urbans, etc.). This new functionality cannot be accessed by IHS (Federal) locations.

The ERA options contain posting restrictions that were put into place several years ago to comply with UFMS reporting requirements for Federal locations. Until the release of p24 these restrictions were also applied to non-IHS locations (Tribes, Urbans, etc.) and have prevented the following scenarios from being posted via the ERA:

- Transactions applied to a cancelled bill
- Transactions that will create a negative bill balance
- Transactions that will create a negative collection batch or item balance

This patch contains new fields in the Site Parameter Edit option (BAR > MAN > SPE) that allows non-IHS locations to turn off the ERA posting restrictions, if desired.

This is how these new fields work:

- **ALLOW ERA POSTING NEG BAL** - Answering this prompt with Yes will not restrict the ERA from creating negative balances on bills, Collection Batches, or Collection Batch Items. The default answer for this prompt is No. Answering this prompt with No will restrict the ERA from creating any negative balances. ERA transactions that will put a bill, collection batch or collection batch item into a negative will be marked with the appropriate Reason Not to Post in the Review Postable Claims option (BAR > PST > ERA > REV). Bills marked with either or both of these Reasons Not to Post will have to be posted manually.

```
BAR Claim Review    Apr 02, 2014 09:27:24          Page:    1 of    0
HIPAA 835 v5010     File: 1005_ERA_03/05/2014     Chk/EFT#: 486759

 #  Claim             Date         Patient           AR Account  Status
1   30571A            20080715     PATIENT,PRIVATE               MATCHED
                     **********REASONS NOT TO POST********
                   NEGATIVE BALANCE WILL RESULT IN RPMS BILL
                    ERA TOTAL GREATER THAN BATCH/ITEM TOTAL
    30571A-TC-5216    JUL 15, 2008 PATIENT,PRIVATE    MEDICARE
```

Figure 2-6: Example of Reasons Not to Post for negative balances.

- **ALLOW POSTING CANC. BILLS** - Answering this prompt with Yes will not restrict the ERA from posting to cancelled bills. The default answer for this prompt is No. Answering this prompt with No will restrict the ERA from posting to cancelled bills. Cancelled bills will be marked with the Reason Not to Post in the Review Postable Claims option (BAR > PST > ERA > ERA). Bills marked with this Reason Not to Post will have to be posted manually.

```
BAR Claim Review   Apr 02, 2014 09:09:18         Page:    1 of    0
HIPAA 835 v5010    File: 1001_ERA_02/11/2014     Chk/EFT#: 486759

 #  Claim           Date            Patient         AR Account    Status
1   30571A         20080715     PATIENT,PRIVATE      MEDICARE    MATCHED
                     **********REASONS NOT TO POST********
                    RA CLAIM IN RPMS AR BUT CANCELLED IN 3P
    30571A-TC-5216 JUL 15, 2008 PATIENT,PRIVATE      MEDICARE
```

Figure 2-7: Example of Reason Not to Post for a cancelled bill.

As mentioned previously, these new parameters are located in the Site Parameter Edit option (BAR > MAN > SPE). When this patch is installed those parameters will automatically be populated with the default response of No. To change the response to Yes for either or both of these prompts:

1. At the “Select A/R SITE PARAMETER/IHS RPMS SITE” prompt, type the name of the facility to be edited and press Enter.

2. Press Enter through the prompts to get to the new fields, which are located towards the bottom of the SPE option immediately after the UFMS fields.
3. At the "ALLOW ERA POSTING NEG BAL" prompt, type **Yes** and press Enter to allow the ERA to create negative balances.
   - To leave the ERA negative balance in place, press Enter.
4. At the "ALLOW ERA POSTING CANC. BILLS" prompt, type **Yes** and press Enter to allow the ERA to post transactions to cancelled bills.
   - To leave the ERA cancelled bill restriction in place, press Enter.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p24          |
          +                  Site Parameter Edit                    +
          |                  TRIBAL HEALTH CENTER                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: CARLTON,GINA            BUSINESS OFFICE     2-APR-2014 2:52 PM

Select A/R SITE PARAMETER/IHS RPMS SITE: TRIBAL HEALTH CENTER       ALBUQUERQUE
TRIBE/638       ALBUQUERQUE       98    NM
         ...OK? Yes//   (Yes)
UFMS SHUTDOWN FILE TRANSFER: YES//
UFMS SHUTDOWN SESSION LOGGING: YES//
ALLOW ERA POSTING NEG BAL: NO//
ALLOW ERA POSTING CANC. BILLS: NO//
OMB DIRECTORY:
```

Figure 2-8: Example of new fields available to non-IHS facilities in the SPE option.

2.5 Reports

2.5.1 Batch Posted Payments

BAR > RPT > BRM > BPP

A field was added to the Batch Posted Payments report for the bill date of service, as shown in Figure 2-9.

```
PRIVATE_GC-02/10/2014-1POSTINGS ***CONFIDENTIAL PATIENT INFORMATION***
                                                MAR 21,2014  08:25    PAGE 1
IT   BILL (A/R)              PMT  DT / DOS   BILLED TO        PATIENT
-------------------------------------------------------------------------------

             A/R ACCOUNT: BCBS OF NEW MEXICO
1    31249-IH-130214    500.00  02/21/2014 BCBS OF NEW MEX  PATIENT,PRIVATE
                                12/11/2013
     31268-IH-100214      2.45  02/20/2014 BCBS OF NEW MEX  DEMO,ACCOUNT
                                01/09/2014
             A/R ACCOUNT: AETNA
     30981A-A             2.76  02/20/2014 AETNA            PRIVATE,DEMO
                                12/18/2013
                       ----------
SUBTOTAL                   505.21
                       ----------
TOTAL                      505.21
```

Figure 2-9: Example of new field for bill date of service on Batch Posted Payments report.

2.5.2 Transaction Statistical Report

BAR > RPT > FRM > TSR

A field was added to the Transaction Statistical Report to report the date of service from the bill as shown in Figure 2-10 and Figure 2-11. Depending on whether the report is generated for payments or for adjustments, the date of service will be displayed in a different location.

When generated to report for payments, the date of service from the bill is displayed on the far right side of the report.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
DETAIL Transaction Statistical Report           MAR 21,2014@08:42   Page 1
for ALL BILLING SOURCE(S)
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location
with TRANSACTION DATES from 03/01/2014 to 03/15/2014
================================================================================
Bill           Transaction                 Amount     Transaction      DOS
Number             Date         Insurer     Billed        Amount
================================================================================
Visit Location.......: INDIAN HEALTH HOSPITALPAYMENT
          Data Source..........: MANUAL
          Visit Type...........: OUTPATIENT

31294A-IH-1002 03/14/2014  BCBS OF NEW MEX   90.00        50.00m 01/20/2014
                                          ----------     ----------
                        Visit Type Tot:       90.00        50.00

          Visit Type...........: EMERGENCY ROOM

31109B-IH-3948 03/04/2014  PATIENT,DEMO     250.00       250.00m 12/21/2013
                                          ----------     ----------
                        Visit Type Tot:      250.00       250.00
                        Data Source Tot:     340.00       300.00
```

```
          Totals by Transaction type:       340.00       300.00

Location Tot:                               340.00       300.00

                                         ==========    ==========
REPORT TOTAL                                340.00       300.00

                *****  R E P O R T  C O M P L E T E  *****
```

Figure 2-10: Example of new field in Transaction Statistical Report when run for payments.

A reported generated for adjustments displays the date of service under the Transaction Date. This is because the Adjustment Type is displayed in the far right column.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
DETAIL Transaction Statistical Report            MAR 21,2014@08:57   Page 1
for ALL BILLING SOURCE(S)
at INDIAN HEALTH HOSPITAL Visit location under INDIAN HEALTH HOSPITAL
Billing Location with TRANSACTION DATES from 03/01/2014 to 03/10/2014
================================================================================
Bill           Transaction                Amount   Transaction  Adjustment
Number             Date       Insurer     Billed        Amount        Type
                   DOS
================================================================================
 Visit Location.......: INDIAN HEALTH HOSPITAL
     Adjustment Category.......: CO-PAY
          Data Source..........: MANUAL
          Visit Type...........: OUTPATIENT

14472A-JSU     03/06/2014  NEW MEXICO MEDI   152.00     50.00m Co-Payment A
               10/15/2013
                                          ----------   --------
                    Adjustment Type Tot:     152.00     50.00

                                          ----------  --------
          Totals by Adjustment Category:      152.00    50.00

     Adjustment Category.......: WRITE OFF
31289A-IH-1302 03/06/2014  BENEFICIARY PAT    62.00     62.00m INDIAN BENEF
               01/25/2014
                                         ----------     ----------
                    Adjustment Type Tot:      62.00         62.00

                                         ----------     ----------
          Totals by Adjustment Category:       62.00        62.00

     Adjustment Category.......: NON PAYMENT
14472A-JSU     03/06/2014  NEW MEXICO MEDI    152.00   100.00m Chrgs Excd M
               10/15/2013
31249-IH-13021 03/06/2014  MEDICARE           418.57   100.00m Chrgs Excd M
               12/11/2013
                                         ----------   ----------
                         Visit Type Tot:      784.57       112.00
                         Data Source Tot:     784.57       112.00

          Totals by Adjustment Category:      570.57         0.00
```

```
Location Tot:                                784.57       112.00

                                          ==========     ==========
REPORT TOTAL                                 784.57       112.00

               *****  R E P O R T  C O M P L E T E  *****
```

Figure 2-11: Example of new field in Transaction Statistical Report when run for adjustments.

2.5.3 Non-Beneficiary Payment Report

BAR > RPT > FRM > NBR

This new report provides payment information for bills that belong to non-beneficiary patients. The Non-Beneficiary Payment Report (NBR) will only provide data on bills that have an insurance payment or a patient payment posted, or both. It can be run by detail or by summary. The detail option will provide data by individual bill number (A bill, B bill, etc.). The summary option will add up the payment information for all bills that are associated with an original bill (A bill, B bill, etc.) and provide summary totals for the core bill number. The billed amount will only be calculated once regardless of whether the report is run by detail or by summary.

There are three parameters available for running the NBR:

- Location
- Date Range
- Specific Patient

The report defaults to All Visit Locations and for Report Type of Detail but that can be changed, if desired.

```
Select Financial Reports Menu Option: NBR  Non-Ben Payment Report

NOTE: This report will contain data for the BILLING location you are logged
      into.  Selecting a Visit Location will allow you to run the report
      for a specific VISIT location under this BILLING location.

   INCLUSION PARAMETERS in Effect for Non-Ben Payment Report:
   ------------------------------------------------------------------------
   - Visit Location........: ALL
   - Report Type...........: DETAIL

     Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         SPECIFIC PATIENT

Select ONE or MORE of the above INCLUSION PARAMETERS:
```

Figure 2-12: Example of the available inclusion parameters in the Non-Ben Payment Report.

Use the following steps to generate the Non-Ben Payment Report:

1. To restrict the report to one visit location, type **1** or **Location** at the "Select ONE or MORE of the above INCLUSION PARAMETERS" prompt and press Enter.
   - If nothing is selected at this prompt, the report will provide data for all Locations.
2. The NBR requires that a date range be selected. Type **2** or **Date Range** at the "Select ONE or MORE of the above INCLUSION PARAMETERS" prompt and press Enter.
3. At the "Select TYPE of DATE Desired" prompt, do one of the following:
   - To run the report by bill Visit Date, type **1** and press Enter.
   - To run the report by Transaction Date, type **2** and press Enter.
4. Type the desired date range and press Enter. The selections made to this point display in the Inclusion Parameter summary as shown in Figure 2-3.

```
   INCLUSION PARAMETERS in Effect for Non-Ben Payment Report:
   ========================================================================
   - Visit Location........: ALL
   - Transaction Dates from..: 01/01/2014  to: 01/31/2014
   - Report Type...........: DETAIL

     Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         SPECIFIC PATIENT

Select ONE or MORE of the above INCLUSION PARAMETERS:
```

Figure 2-13: Example of the inclusion parameter summary.

5. At the "Select ONE or MORE of the above INCLUSION PARAMETERS" prompt, do one of the following:
   - To run the report for all patients, press Enter.
   - To run the report for a specified patient, type **3** and press Enter. At the "Select PATIENT NAME" prompt, type the desired patient name or Health Record Number and press Enter.
     – If the wrong patient was selected, choose the SPECIFIC PATIENT parameter again and enter the name of the desired patient.

```
   INCLUSION PARAMETERS in Effect for Non-Ben Payment Report:
   ========================================================================
   - Visit Location........: ALL
   - Transaction Dates from..: 01/01/2014  to: 01/31/2014
   - Report Type...........: DETAIL
```

```
     Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         SPECIFIC PATIENT

Select ONE or MORE of the above INCLUSION PARAMETERS: 3  SPECIFIC PATIENT
Select PATIENT NAME: PATIENT,DEMO
```

Figure 2-14: Example of running the NBR by specific patient.

6. Determine whether to run the report by Detail or by Summary. At the "Select TYPE of REPORT" prompt, do one of the following:

   - Press Enter to run the report by Detail.
   - Type **1** or **Summary** and press Enter to run the report by Summary.

```
Select ONE or MORE of the above INCLUSION PARAMETERS:

     Select one of the following:

          1         Detail
          2         Summary

Select TYPE of REPORT : 1//
```

Figure 2-15: Example of the available report types.

The Detail report will provide payment information by individual bill number (A bill, B bill, etc.) and will then provide totals by bill number, as shown in Figure 2-16.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
Non-beneficiary Detailed Report with VISIT DATES  MAR 31,2014@10:25  Page 2
from 01/01/2014 to 01/31/2014
 at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location
================================================================================
Bill      Pt Payment         Amount        Insurance      Patient
Number   Posted Date         Billed        Payment        Payment   Balance
================================================================================

31295A-IH-100214
                           90.00          50.00           0.00       0.00
31295C-IH-100214
          03/31/2014       40.00           0.00          40.00       0.00
                     --------------- -------------- -------------- -------
*** BILL 31295 Total      130.00          50.00          40.00       0.00
```

Figure 2-16: Example of NBR run by Detail.

The Summary report adds up insurance payments and patient payments that have been posted to all bills associated with a claim (A bill, B bill, etc.) and will display the totals on one line of the report for the core claim.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
Non-beneficiary Summary Report with VISIT DATES   MAR 31,2014@10:29  Page 1
from 01/01/2014 to 01/31/2014
 at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location
================================================================================
Bill                          Amount        Insurance     Patient
Number                        Billed        Payment       Payment
Balance
================================================================================

*** VISIT Location: INDIAN HEALTH HOSPITAL

31295                         130.00          50.00        40.00        0.00
                          --------------- -------------- -------------- --------
*** VISIT Loc Total           130.00          50.00        40.00        0.00
                        =============== ============== ============== =========
***** REPORT Total            130.00          50.00        40.00        0.00
```

Figure 2-17: Example of NBR run by Summary.

The reports in Figure 2-16 and Figure 2-17 were run for the same inclusion parameters. Note that in the second example the totals for the A bill and C bill are summarized on one line.

Appendix A: SAR Codes

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
1	Deductible Amount	Deductible Amount	13	Deductible	29	Deductible
2	Coinsurance Amount	Coinsurance Amount	14	Co-pay	602	Coinsurance Amount
3	Co-payment Amount	Co-payment Amount	14	Co-pay	27	Co-payment
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Procedure code inconsistent w/modifier or modifier missing	4	Non Payment	604	Code Err Proc Inconst w Mod
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Procedure code/bill type inconsistent with place of service	4	Non Payment	605	Code Err Proc/BT Inconst w POS
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Procedure/Revenue code inconsistent with patient's age	4	Non Payment	606	Code Err Proc Inconst w Pt Age
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Procedure/Revenue code inconsistent with patient's gender	4	Non Payment	607	Code Err Proc Inconst w Pt Gdr

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Procedure code inconsistent with provider type/specialty (taxonomy)	4	Non Payment	608	Code Err Proc Inconst w ProvTp
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Diagnosis inconsistent with patient's age	4	Non Payment	609	Code Err DX Inconst w Pt Age
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Diagnosis inconsistent with patient's gender	4	Non Payment	610	Code Err DX Inconst w Pt Gdr
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Diagnosis inconsistent with procedure	4	Non Payment	611	Code Err DX Inconst w Procdr
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Diagnosis inconsistent with provider type	4	Non Payment	612	Code Err DX Inconst w Prov Tp
13	The date of death precedes the date of service.	The date of death precedes the date of service	4	Non Payment	613	Death Precedes Date of Service
14	The date of birth follows the date of service.	The date of birth follows the date of service	4	Non Payment	614	Birth Follows Date of Service

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	Auth # missing, invalid, or does not apply to billed svc or prv	4	Non Payment	615	Pymt Adj Inadeq Auth Number
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Claim/service lacks info or has submission/billing error(s) needed for adjudication	4	Non Payment	616	Clm/Srvc Lacks Info For Adjud
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark code or NCPDP Reject Reason Code).	Requested info not provided or insufficient/incomplete	4	Non Payment	617	Pymt Adj Info Incomplete
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	Duplicate claim/service	3	Write Off	135	Duplicate Claim/Service
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	Work related injury/illness-liability of Work Comp Carrier	4	Non Payment	619	Clm Denied work Related injury
20	This injury/illness is covered by the liability carrier.	Injury/illness is covered by the liability carrier	4	Non Payment	620	Clm Den injry Covrd Liab Carr

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
21	This injury/illness is the liability of the no-fault carrier.	Injury/illness is the liability of the no-fault carrier	4	Non Payment	621	Clm Den Injry Covrd NoFlt Carr
22	This care may be covered by another payer per coordination of benefits.	Care may be covered by another payer per coord of benefits	4	Non Payment	622	Pymt Adj Care Covrd Diff Payer
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	The impact of prior payer(s) adjudication including payments and/or adjustments	4	Non Payment	623	Pymt Adj Chrgs Pd by Diff Pyr
24	Charges are covered under a capitation agreement/managed care plan.	Charges covered under cap agreemnt/ managed care	4	Non Payment	624	Pymt Adj Chrgs Covrd Capit Agr
25	Payment denied. Your Stop loss deductible has not been met.	Payment denied. Stop loss deductible has not been met	4	Non Payment	625	Pymt Den Stoploss Ded Not Met
26	Expenses incurred prior to coverage.	Expenses incurred prior to coverage	4	Non Payment	626	Expnse Incrrd Prior to Coverag
27	Expenses incurred after coverage terminated.	Expenses incurred after coverage terminated	4	Non Payment	627	Expnse Incrrd Aft Cov Termnatd
28	Coverage not in effect at the time the service was provided. Notes: Redundant to codes 26 & 27	Coverage not in effect at the time the service was provided	4	Non Payment	628	Coverage Not in Effect on DOS
29	The time limit for filing has expired.	The time limit for filing has expired	4	Non Payment	134	Time Limit for Filing Expired

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Payment adjusted-patient not met required elig, spend down, wait, or res reqmnts	4	Non Payment	630	Pymt Adj Pt Not Met Requiremts
31	Patient cannot be identified as our insured.	Patient cannot be identified as insured	4	Non Payment	166	Clm Den Pt Not Identifd Isurd
32	Our records indicate that this dependent is not an eligible dependent as defined.	Our records indicate that dependent is not eligible dependent as defined	4	Non Payment	632	Records Indicate Dep Not Elig
33	Insured has no dependent coverage.	Insured has no dependent coverage	4	Non Payment	633	Clm Den Insured No Depnd Cov
34	Insured has no coverage for newborns.	Insured has no coverage for newborns	4	Non Payment	17	Clm Den Insured no Cov for NB
35	Lifetime benefit maximum has been reached.	Lifetime benefit maximum has been reached	4	Non Payment	167	Benefits Maximum Reached
36	Balance does not exceed co-payment amount.	Balance does not exceed co-payment amount	4	Non Payment	636	Bal Does not Exceed CoPymt Amt
37	Balance does not exceed deductible.	Balance does not exceed deductible	4	Non Payment	637	Bal Does not Exceed Deductible
38	Services not provided or authorized by designated (network/primary care) providers.	Services not provided or authorized by designated (network) providers	4	Non Payment	638	Serv Not Auth by Designtd Prov

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
39	Services denied at the time authorization/pre-certification was requested.	Services denied at the time authorization/pre-certification was requested	4	Non Payment	639	Srvcs Den At Time Auth Rqsted
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Charges do not meet qualifications for emergent/urgent care	4	Non Payment	640	Chrgs DoNotMeet Criteria ER/UC
41	Discount agreed to in Preferred Provider contract.	Discount agreed to in Preferred Provider contract	4	Non Payment	168	Disc Agrmt Pref Prov Contract
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	Charges exceed our fee schedule or maximum allowable amount	4	Non Payment	21	Chrgs Excd Max Allowable Amt
43	Gramm-Rudman reduction.	Gramm-Rudman reduction	4	Non Payment	643	Gramm-Rudman reduction
44	Prompt-pay discount.	Prompt-pay discount	4	Non Payment	644	Prompt Pay Discount
45	Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	Charges exceed fee schedule/max allow or contracted/legislated fee arrangement	4	Non Payment	645	Chrgs Excd Contrct Fee Arrngmt
46	This (these) service(s) is (are) not covered. Notes: Use code 96.	This (these) service(s) is (are) not covered	4	Non Payment	122	Services Not Covered

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	This (these) diagnosis(es) is (are) not covered, missing, or are invalid	4	Non Payment	647	Dx not Covered/Missing/Invalid
48	This (these) procedure(s) is (are) not covered. Notes: Use code 96.	This (these) procedure(s) is (are) not covered	4	Non Payment	648	Procedure Not Covered
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Non-covered services-routine exam/screening proc in conj w/routine exam	4	Non Payment	20	Non Cov Srv Routine Exam
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Non-covered services-not deemed a `medical necessity' by the payer	4	Non Payment	169	Non Cov Srv Not Medically Nec
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Non-covered services-pre-existing condition	4	Non Payment	19	Non Cov Srv PreExist Condition
52	The referring /prescribing/ rendering provider is not eligible to refer/ prescribe/ order/ perform the service billed.	Ref/prescrib/render/Prv not eligible to ref/prescrib/order/perform svc billed	4	Non Payment	178	Prov Not Elig to Provd Serv/Bl

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
53	Services by an immediate relative or a member of the same household are not covered.	Services by an immediate relative/member of the same household are not covered	4	Non Payment	653	Serv by Mbr of Hshld Not Cover
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Multiple physicians/assistants are not covered in this case	4	Non Payment	654	Mult Prov Not Cov in This Case
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Claim/svc denied-proc/trtmnt deemed experimental/investigational by the payer	4	Non Payment	655	Clm Den Proc/TX Experimental
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Claim/svc denied-proc/trtmnt not deemed `proven to be effective' by the payer	4	Non Payment	656	Clm Den Proc not dmd Effective
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. Notes: Split into codes 150, 151, 152, 153, and 154.	Payment denied/reduced-doc not support level/#/length of svc/dosage/day's supply	4	Non Payment	657	Pymt Den Info Submtd Not Suff
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Payment adjusted-trtmnt rendered in inappropriate/invalid place of svc	4	Non Payment	658	Pymt Adj Tx Prov Invalid POS

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Charges adjusted-multiple surgery rules/concurrent anesthesia rules	4	Non Payment	659	Chrgs Adj Mult Surg Anesth Rul
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	Charges for outpat svcs w/this proximity to inpat svcs not covered	4	Non Payment	660	Non Cov Srv OP/IP Proximity
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Charges adjusted-penalty for failure to obtain second surgical opinion	21	Pending	661	Chrgs Adj Penlty No Secnd Opin
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	Payment denied/reduced-absence of/exceeded, pre-certification/ authorization	15	Penalty	662	Pymt Den/Reducd No Precrt Auth
63	Correction to a prior claim.	Correction to a prior claim	4	Non Payment	663	Correction to Prior Claim
64	Denial reversed per Medical Review.	Denial reversed per Medical Review	22	Gen Information	664	Denial reversed per Med Review
65	Procedure code was incorrect. This payment reflects the correct code.	Procedure code was incorrect. This payment reflects the correct code	4	Non Payment	665	Pymt Den/Reducd Proc Code Wrong
66	Blood Deductible.	Blood Deductible	13	Deductible	666	Blood Deductible

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	Lifetime reserve days	4	Non Payment	667	Lifetime Reserve Days
68	DRG weight. (Handled in CLP12)	DRG weight	16	Grouper Allowance	93	DRG Weight
69	Day outlier amount.	Day outlier amount	4	Non Payment	669	Day Outlier Amount
70	Cost outlier - Adjustment to compensate for additional costs.	Cost outlier - Adjustment to compensate for additional costs	4	Non Payment	670	Cost Outlr Adj for Addl Cost
71	Primary Payer amount. Notes: Use code 23	Primary Payer amount	4	Non Payment	165	Primary Payer Amount
72	Coinsurance day. (Handled in QTY, QTY01=CD)	Coinsurance day	14	Co-pay	672	Coinsurance Day
73	Administrative days.	Administrative days	4	Non Payment	673	Administrative Days
74	Indirect Medical Education Adjustment.	Indirect Medical Education Adjustment	4	Non Payment	674	Indirect Med Ed Adj
75	Direct Medical Education Adjustment.	Direct Medical Education Adjustment	4	Non Payment	675	Direct Med Ed Adj
76	Disproportionate Share Adjustment.	Disproportionate Share Adjustment	4	Non Payment	676	Disproportionate Share Adj
77	Covered days. (Handled in QTY, QTY01=CA)	Covered days	4	Non Payment	677	Covered Days
78	Non-Covered days/Room charge adjustment.	Non-Covered days/Room charge adjustment	4	Non Payment	678	Non Covered Days/Room Chrg Adj

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
79	Cost Report days. (Handled in MIA15)	Cost Report days	4	Non Payment	679	Cost Report Days
80	Outlier days. (Handled in QTY, QTY01=OU)	Outlier days	4	Non Payment	680	Outlier Days
81	Discharges.	Discharges	4	Non Payment	681	Discharges
82	PIP days.	PIP days	4	Non Payment	682	PIP days
83	Total visits.	Total visits	4	Non Payment	683	Total visits
84	Capital Adjustment. (Handled in MIA)	Capital Adjustment	4	Non Payment	684	Capital Adjustment
85	Patient Interest Adjustment (Use Only Group code PR) Notes: Only use when the payment of interest is the responsibility of the patient.	Patient interest amount	4	Non Payment	685	Patient Interest Amount
86	Statutory Adjustment. Notes: Duplicative of code 45.	Statutory Adjustment	4	Non Payment	686	Statutory Adjustment
87	Transfer amount.	Transfer amount	4	Non Payment	687	Transfer Amount
88	Adjustment amount represents collection against receivable created in prior overpayment.	Adj amt represents collection against receivable created in prior overpayment	21	Pending	688	Adj Amt Rep Rec Prior OvrPymt
89	Professional fees removed from charges.	Professional fees removed from charges	4	Non Payment	689	Pro Fees Removed from Charges
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	Ingredient cost adjustment	4	Non Payment	690	Ingredient Cost Adj

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
91	Dispensing fee adjustment.	Dispensing fee adjustment	3	Write Off	691	Dispensing Fee Adj
92	Claim Paid in full.	Claim Paid in full	22	Gen Information	692	Claim Paid In Full
93	No Claim level Adjustments. Notes: As of 004010, CAS at the claim level is optional.	No Claim level Adjustments	22	Gen Information	693	No Claim level adjustments
94	Processed in Excess of charges.	Processed in Excess of charges	16	Grouper Allowance	694	Processed in Excess of Charges
95	Plan procedures not followed.	Plan procedures not followed	4	Non Payment	695	Ben Adj Plan Proc Not Followed
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Non-covered charge(s)	4	Non Payment	696	Non Covered Charge(s)
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Benefit included in the payment/allow for another service/procedure already adjud	4	Non Payment	697	Pymt Incld Allow for Diff Srv
98	The hospital must file the Medicare claim for this inpatient non-physician service.	Hospital must file Medicare claim for this inpatient non-physician service	21	Pending	698	Hosp Must File Medicare Claim

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
99	Medicare Secondary Payer Adjustment Amount.	Medicare Secondary Payer Adjustment Amount	4	Non Payment	699	MSP Adjustment Amount
100	Payment made to patient/insured/responsible party/employer.	Payment made to patient/insured/ responsible party/employer	4	Non Payment	23	Pymt Made to PT/Insrd/Rsp Prty
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	Predetermination: anticipate payment upon completion of svcs/claim adjudication	21	Pending	701	Predetermined Antcptd Pymt
102	Major Medical Adjustment.	Major Medical Adjustment	4	Non Payment	702	Major Medical Adjustment
103	Provider promotional discount (e.g., Senior citizen discount).	Provider promotional discount (e.g., Senior citizen discount)	4	Non Payment	703	Provider Promotional Discount
104	Managed care withholding.	Managed care withholding	4	Non Payment	704	Managed Care Withholding
105	Tax withholding.	Tax withholding	4	Non Payment	705	Tax Withholding
106	Patient payment option/election not in effect.	Patient payment option/election not in effect	4	Non Payment	706	Pt Pymt Option not in Effect
107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Related or qualifying claim/service not identified on claim	4	Non Payment	707	Clm Den Reltd Srv Not Identifd

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Rent/purchase guidelines were not met	4	Non Payment	708	Pymt Reduce-Guidelines Not Met
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	Claim not covered by payer/contractor. Send claim to correct payer/contractor	4	Non Payment	709	Clm not Covered by this Payer
110	Billing date predates service date.	Billing date predates service date	4	Non Payment	710	Billing Date Precedes DOS
111	Not covered unless the provider accepts assignment.	Not covered unless the provider accepts assignment	4	Non Payment	711	Not Cov Unlss Prov Acpts Asnmt
112	Service not furnished directly to the patient and/or not documented.	Payment adjusted as not furnished directly to the patient and/or not documented	4	Non Payment	180	Pymt Adj Not Furn/Prov to PT
113	Payment denied because service/procedure was provided outside the United States or as a result of war. Notes: Use Codes 157, 158, or 159	Payment denied-service/procedure provided outside the US or as a result of war	4	Non Payment	713	Pymt Den Srv Prov Outside US
114	Procedure/product not approved by the Food and Drug Administration.	Procedure/product not approved by the Food and Drug Administration	4	Non Payment	714	Proc/Srv Not Approved by FDA
115	Procedure postponed, canceled, or delayed.	Procedure postponed or canceled	4	Non Payment	715	Pymt Adj Proc Postponed Cancel

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
116	The advance indemnification notice signed by the patient did not comply with requirements.	Advance indemnification notice signed by the patient did not comply w/requirements	4	Non Payment	716	Pymt Den Adv Indmn Ntc NoCmply
117	Transportation is only covered to the closest facility that can provide the necessary care.	Transport only covered closest facility that can provide necessary care	4	Non Payment	717	Pymt Den Transp Not Covered
118	ESRD network support adjustment.	ESRD network support adjustment	4	Non Payment	718	Chgs Reduce - ESRD Support
119	Benefit maximum for this time period or occurrence has been reached.	Benefit maximum for this time period or occurrence has been reached	4	Non Payment	719	Max Benefits for Time Period
120	Patient is covered by a managed care plan. Notes: Use code 24.	Patient is covered by a managed care plan	4	Non Payment	720	Pt Cov by Managed Care Plan
121	Indemnification adjustment - compensation for outstanding member responsibility.	Indemnification adjustment	4	Non Payment	721	Indemnification Adjustment
122	Psychiatric reduction.	Psychiatric reduction	4	Non Payment	722	Psychiatric Reduction
123	Payer refund due to overpayment.	Payer refund due to overpayment	22	Gen Information	723	Payer refund due to ovrpymt
124	Payer refund amount - not our patient. Notes: Refer to implementation guide for proper handling of reversals.	Payer refund amount - not our patient	22	Gen Information	724	Payer refund Amt - not out pt

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Submission/billing error(s)	4	Non Payment	725	Pymt adj due to billing errors
126	Deductible -- Major Medical Notes: Use Group Code PR and code 1.	Deductible -- Major Medical	13	Deductible	726	Deductible - Major Medical
127	Coinsurance -- Major Medical Notes: Use Group Code PR and code 2.	Coinsurance -- Major Medical	14	Co-pay	727	Coinsurance - Major Medical
128	Newborn's services are covered in the mother's Allowance.	Newborn's services are covered in the mother's Allowance	4	Non Payment	728	NB Srvc Cov in Mother's Allow
129	Prior processing information appears incorrect.	Prior processing information appears incorrect	4	Non Payment	164	Pymt Den Prior Info Incorrect
130	Claim submission fee.	Claim submission fee	4	Non Payment	730	Claim Submission Fee
131	Claim specific negotiated discount.	Claim specific negotiated discount	4	Non Payment	731	Clm Specific Negotiated Disct
132	Prearranged demonstration project adjustment.	Prearranged demonstration project adjustment	4	Non Payment	732	Pre-Arranged Demo Proj Adj
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)	The disposition of this claim/service is pending further review	21	Pending	733	Claim Pending Further Review
134	Technical fees removed from charges.	Technical fees removed from charges	4	Non Payment	734	Tech Fees Removed From Chrgs

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
135	Interim bills cannot be processed.	Interim bills cannot be processed	4	Non Payment	735	Clm Den Intrm Bill Cannot Proc
136	Failure to follow prior payer's coverage rules. (Use Group Code OA).	Failure to follow prior payer's coverage rules	4	Non Payment	736	Clm Adj PriorPayor P&P Not don
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	Regulatory Surcharges/ Assessments/ Allowances/Health Related Taxes	4	Non Payment	141	Pymt Red Srchrg Assess Taxes
138	Appeal procedures not followed or time limits not met.	Appeal procedures not followed or time limits not met	4	Non Payment	738	Clm Den Appeal Proc Not Follow
139	Contracted funding agreement - Subscriber is employed by the provider of services.	Contracted funding agreement - Subscriber employed by the provider of services	4	Non Payment	739	Cntrct Agrmt Sub emplyd by prov
140	Patient/Insured health identification number and name do not match.	Patient/Insured health identification number and name do not match	4	Non Payment	740	Pt ID# & Name do not match
141	Claim spans eligible and ineligible periods of coverage.	Claim spans eligible and ineligible periods of coverage	4	Non Payment	125	Clm Adj Spans Elig/Inelig Date
142	Monthly Medicaid patient liability amount.	Monthly Medicaid patient liability amount	4	Non Payment	742	Clm Adj Medicaid Pt Liab Amt
143	Portion of payment deferred.	Portion of payment deferred	21	Pending	743	Portion of Payment deferred

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
144	Incentive adjustment, e.g. preferred product/service.	Incentive adjustment, e.g. preferred product/service	4	Non Payment	744	Incentive Adjustment
145	Premium payment withholding Notes: Use Group Code CO and code 45	Premium payment withholding	4	Non Payment	745	Premium Pymt Withholding
146	Diagnosis was invalid for the date(s) of service reported.	Diagnosis invalid for the date(s) of service reported.	4	Non Payment	746	Pmt Den DX Invalid for DOS
147	Provider contracted/negotiated rate expired or not on file.	Provider contracted/negotiated rate expired or not on file.	4	Non Payment	747	Prv Rate Expired/Not on file
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Information from another provider was not provided or was insuff/incomplete	4	Non Payment	748	Clm/Srv Rej Prov Info Incmplt
149	Lifetime benefit maximum has been reached for this service/benefit category.	Lifetime benefit maximum has been reached for this service/benefit category.	4	Non Payment	749	Lifetime Ben Max for Srv/Ben
150	Payer deems the information submitted does not support this level of service.	Payer deems the info submitted not support this level of service.	4	Non Payment	754	Pymt Adj No Info Level of Svc
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	Pmt adjusted - payer deems the info submitted not support this many svcs.	4	Non Payment	750	Pymt Adj No Info Sprt Many Svc

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Payer deems the info submitted not support this lgth of svc.	4	Non Payment	751	Pymt Adj No Info Lngth of Svc
153	Payer deems the information submitted does not support this dosage.	Payer deems the info submitted not support this dosage.	4	Non Payment	752	Pymt Adj No Info for Dosage
154	Payer deems the information submitted does not support this day's supply.	Payer deems the info submitted not support this day's supply.	4	Non Payment	753	Pymt Adj No Info Days Supply
155	Patient refused the service/procedure.	Patient refused the service/procedure	4	Non Payment	755	Clm Den Pt Refused Srv/Proc
156	Flexible spending account payments. Note: Use code 187.	Flexible spending account payments.	22	Gen Information	756	Flex Spending Acct Pymnt
157	Service/procedure was provided as a result of an act of war.	Service/procedure provided as a result of an act of war.	4	Non Payment	757	Pmt Den/Red Result Act of War
158	Service/procedure was provided outside of the United States.	Service/procedure provided outside the United States.	4	Non Payment	758	Pmt Den/Red Outside US
159	Service/procedure was provided as a result of terrorism.	Service/procedure provided as a result of terrorism.	4	Non Payment	759	Pmt Den/Red Result of Terrorsm
160	Injury/illness was the result of an activity that is a benefit exclusion.	Injury/illness result of activity that's a benefit exclusion	4	Non Payment	760	Pmt Den/Red Activity Ben Excl
161	Provider performance bonus.	Provider performance bonus	16	Grouper Allowance	922	Provider Performance Bonus

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.	State-mandated requirement for property/casualty--see claim payment remark codes	4	Non Payment	762	Property & Casualty Require
163	Attachment referenced on the claim was not received.	Attachment referenced on the claim was not received	21	Pending	763	Clm/Svc Adj No Attachment Rec
164	Attachment referenced on the claim was not received in a timely fashion.	Attachment regerenced on the claim was not received in a timely fashion	4	Non Payment	764	Clm/Svc Adj Attach not Timely
165	Referral absent or exceeded.	Referral absent or exceeded	15	Penalty	765	Pymt Den/Red No/Exceed Referr
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	Services submitted after this payers resp for processing clms under this plan ended	4	Non Payment	766	Payer Resp for Processing Over
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	This (these) diagnosis(es) is (are) not covered	4	Non Payment	767	DX is Not Covered
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	Svcs have been considered under pts med plan. Benfts not avail under dental plan	4	Non Payment	768	Benefits Not Avail by Dental Plan
169	Alternate benefit has been provided.	Alternate benefit has been provided	4	Non Payment	769	Pymt Adj Alternate Ben Provd

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Payment denied when performed/billed by this type of provider	4	Non Payment	770	Pymt Den Type of Provider
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Payment denied when performed/billed by this type of provider in this type of fac	4	Non Payment	771	Pymt Den Type Provider/Fac
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Payment adjusted when performed/billed by a provider of this specialty	4	Non Payment	772	Pymt Adj Specialty Provider
173	Service/equipment was not prescribed by a physician.	Service/equipment was not prescribed by a physician.	4	Non Payment	773	Pymt Adj Not Prescr by MD
174	Service was not prescribed prior to delivery.	Service was not prescribed prior to delivery	4	Non Payment	774	Pymt Den Not Prsc B4 Deliv
175	Prescription is incomplete.	Prescription is incomplete	4	Non Payment	775	Pymt Den RX Incomplete
176	Prescription is not current.	Prescription is not current	4	Non Payment	776	Pymt Den RX Not Current
177	Patient has not met the required eligibility requirements.	Patient has not met the required eligibility requirements	4	Non Payment	777	Pymt Den PT Not Met Reqrmts

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
178	Patient has not met the required spend down requirements.	Patient has not met the required spend down requirements	4	Non Payment	778	Pymt Adj Pt Spend Dn Not Met
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Patient has not met the required waiting requirements	4	Non Payment	779	Pymt Adj Pt Waiting Req Not Met
180	Patient has not met the required residency requirements.	Patient has not met the required residency requirements	4	Non Payment	780	Pymt Adj Pt Residency Req Not
181	Procedure code was invalid on the date of service.	Procedure code invalid on the date of service	4	Non Payment	781	Pymt Adj Proc Code Inv DOS
182	Procedure modifier was invalid on the date of service.	Procedure modifier was invalid on the date of service	4	Non Payment	782	Pymt Adj Modifier Inv DOS
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Referring provider is not eligible to refer the services billed	4	Non Payment	783	Ref Prov not Elig to Refer
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Prescribing/ordering provider is not eligible to prescribe/order the service billed	4	Non Payment	784	Order Prov not Elig to Order
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Rendering provider not eligibile to perform the service billed	4	Non Payment	785	Rend Prov not Elig to Prvd Svc

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
186	Level of care change adjustment.	Level of care change adjustment	4	Non Payment	786	Pymt Adj Level of Care Chg
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.).	Consumer Spending Acct pymnts (incl Flex Spending, Health Savings, Health Reimburs)	22	Gen Information	787	Health Savings Account Payments
188	This product/procedure is only covered when used according to FDA recommendations.	Product/procedure covered when used according to FDA recommendations	4	Non Payment	788	Proc Cov Only for FDA Rec
189	Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	NOC' or 'unlisted' procedure code (CPT/HCPCS) billed when specific code exists	4	Non Payment	789	NOC/Unlisted Proc Code Used
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	Payment included in allowance for Skilled Nursing Facility (SNF) qualified stay	4	Non Payment	790	Pymt Incl in SNF Qual Stay
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	Not a work related injury/illness and not the liability of the WC carrier	4	Non Payment	791	Clm Den Not Work Related No WC

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	Non Standard adjustment code from paper remittance advice	4	Non Payment	792	Non Std ADJ Code Paper RA
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	Orig pymnt decision maintained - review determined claim was processed properly.	22	Gen Information	793	Clm Properly Proc First Time
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	Anesthesia perf by operating physician, assistant surgeon or attending physician	4	Non Payment	794	Pymt Adj Anes Performed by Prov
195	Refund issued to an erroneous priority payer for this claim/service.	Refund issued to erroneous priority payer for claim/service	19	Refund	795	Pymt Adj Err Refund iss oth pyr
196	Claim/service denied based on prior payer's coverage determination. Notes: Use code 136.	Claim/service denied based on prior payer's coverage determination	4	Non Payment	796	Clm/Svc Den Prior Payor Determ
197	Precertification/authorization/notification absent.	Precertification/ authorization/ notification absent	4	Non Payment	797	Precert/Auth/Notif Absent
198	Precertification/authorization exceeded.	Precertification/ authorization exceeded	4	Non Payment	798	Precert/Auth Exceeded

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
199	Revenue code and Procedure code do not match.	Revenue code and Procedure code do not match	4	Non Payment	799	Rev/Proc Code do not match
200	Expenses incurred during lapse in coverage.	Expenses incurred during lapse in coverage	4	Non Payment	930	Expnse Incrrd Coverag Lapse
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR).	WC Case settled. Pt is responsible thru WC 'Medicare set aside arrang'	4	Non Payment	931	Pt Resp. WC Case Settled
202	Non-covered personal comfort or convenience services.	Non-covered personal comfort or convenience services	4	Non Payment	932	Non Cov Srv Persnal/Convenient
203	Discontinued or reduced service.	Discontinued or reduced service	4	Non Payment	933	Discontinued/Reduced Srvc
204	This service/equipment/drug is not covered under the patient's current benefit plan.	Service/equipment/drug not covered under the patient's current benefit plan	4	Non Payment	934	Srvc Not Cov Under Ben Plan
205	Pharmacy discount card processing fee.	Pharmacy discount card processing fee	3	Writeoff	935	Pharm Disc Card Proc Fee
206	National Provider Identifier - Missing.	National Provider Identifier - Missing	21	Pending	936	NPI Missing
207	National Provider Identifier - Invalid format.	National Provider Identifier - Invalid format	21	Pending	937	NPI Invalid Format
208	National Provider Identifier - Not matched.	National Provider Identifier - Not matched	21	Pending	938	NPI Not Matched

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use Group code OA).	Amt may not be collect from pt. Amt may be billed to subseq pyr. Ref to pt if coll	4	Non Payment	939	Pt Resp. Bill Other Ins.
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	Payment adjusted - Pre-cert/auth not received in a timely fashion	4	Non Payment	940	Pymt Adj Precert Not Timely
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	National Drug Codes (NDC) not eligible for rebate, are not covered	4	Non Payment	941	NDC not elg for rebat not cov
212	Administrative surcharges are not covered.	Administrative surcharges are not covered	4	Non Payment	942	Admin Surcharge Not Covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	Non-compliance with physician self referral prohibition legislation/payer policy	4	Non Payment	943	Non Compliant with Policy

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	WC claim adjusted as noncompensable. Payer not liable for claim or service/treat	4	Non Payment	944	Work Comp Non-Compensable
215	Based on subrogation of a third party settlement	Based on subrogation of a third party settlement	4	Non Payment	945	Subrogation of TP Settlement
216	Based on the findings of a review organization.	Based on the findings of a review organization	4	Non Payment	946	Findings of Review Org.
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only).	Based on payer reasonable and customary fees (WC only)	4	Non Payment	947	Work Comp over UCR

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
218	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	Based on entitlement to benefits (WC only)	4	Non Payment	948	Work Comp entitlement to ben.
219	Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	Based on extent of injury (WC only)	4	Non Payment	949	Work Comp extent of injury
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only).	Applicable fee schedule does not contain the billed code (WC only)	4	Non Payment	950	Work Comp - Bill with Code

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	WC claim under investigation	21	Pending	951	Work Comp - Clm Under Invest
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Exceeds contracted max number of hours/days/units by this provider/this period	4	Non Payment	952	Max Time/Hours for Provider
223	Adjustment code for mandated federal, state, or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	Adjust code for mandated fed/state/local law/reg not covered by another code	4	Non Payment	953	Mandatory Fed/State/Local Reg
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	Pat ID compromised by identity theft. ID verf req for processing this/future clms	4	Non Payment	954	Pt ID compromised by ID theft
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837).	Penalty for interest payment by payer	15	Penalty	919	Penalty/Interest Amt

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Info req from billing/rend provider not provided or insuff/incomplete	4	Non Payment	956	Pymt Adj Prvdr Info Incmplt
227	Information requested from the patient /insured /responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Info req from pt/insured/resp party not provided or insuff/incomplete	4	Non Payment	957	Pymt Adj Pat. Infor Incmplt
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	Denied - This/another prov/subscriber failed to supply req info to prev payer	4	Non Payment	958	Info not Provided to Prev Pyr
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.	Partial charge amt not considered by Medicare due to the initial claim TOB 12X	4	Non Payment	959	Partial Chg Unall due to TOB
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.	No available/correlating CPT/HCPCS to describe this service	4	Non Payment	960	No CPT/HCPCS to describe svc

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Mutually exclusive procedures cannot be done in same day/setting	4	Non Payment	961	Proc not allowed same day/set
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	Institutional transfer amount	4	Non Payment	962	Institutional Trnsfr Amnt
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	Services/charges related to treatment of hosp-acquired cond or preventable med err	4	Non Payment	963	Hosp Aqrd/Medical Error
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	This procedure is not paid separately	4	Non Payment	964	Proc Not Pd Separately
235	Sales Tax	Sales tax	4	Non Payment	965	Sales Tax
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	Proc/proc+mod comb not compat w/oth proc/proc+mod, same day per NCCI	4	Non Payment	966	Proc/mod not comp, othr, NCCI
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Legislated/Regulatory Penalty. Check Remark Codes	15	Penalty	975	Legislative/Regulatory Penalty

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).	Clm spans eligible, inelig periods of coverage, may be the patient's resp	4	Non Payment	967	Clm spans elig/inelg cov-PT
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	Clm spans eligible, inelig periods of coverage. Rebill separate clms	4	Non Payment	969	Clm spans elig/inelg cov-rebil
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Dx inconsistent with pt's birth weight.	4	Non Payment	980	Dx inconsist w pt's birth wt
241	Low Income Subsidy (LIS) Co-payment Amount	Low Income Subsidy (LIS) co-pay amount	14	Co-pay	981	Low Income Subsidy copay amt
242	Services not provided by network/primary care providers.	Svcs not provided by network/primary care providers	4	Non Payment	982	Svcs not provided by netwk/pcp
243	Services not authorized by network/primary care providers.	Svcs not authorized by network/primary care providers	4	Non Payment	983	Svcs not auth'd by network/pcp
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	Pymt red to zero due to lit. Addt'l info will be sent following concl of lit.	21	Pending	984	Pmt reduced to zero due to lit
245	Provider performance program withhold.	Prov performance program withhold.	15	Penalty	985	Prov performance prog withhold
246	This non-payable code is for required reporting only.	This non-payable code is for req'd reporting only.	4	Non Payment	986	Non-payable code for req'd rep

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	Ded for Prof svc rendered in Institutional setting and billed on Inst clm.	13	Deductible	987	Ded-Prof svc rendered in Inst
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	Coins for Prof svc rendered in Institutional setting and billed on Inst clm.	14	Co-pay	988	Coins-Prof svc rendrd in Inst
249	This claim has been identified as a readmission. (Use only with Group Code CO).	Clm identified as a readmission.	4	Non Payment	989	Clm identified as readmission
250	The attachment/other documentation content received is inconsistent with the expected content.	Documentation recv'd is inconsistent w/expected content.	4	Non Payment	300	Doc rcvd inconsist w/exp cntnt
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	Documentation recv'd did not contain content required to process clm/svc.	4	Non Payment	301	Doc rcvd not contain req cntnt
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.	Doc required to adjudicate clm/svc. At least one Remark Code must be provided.	4	Non Payment	302	Doc reqd to adjudicate clm/svc
253	Sequestration - reduction in federal payment	Sequestration - reduction in federal pymt.	15	Penalty	303	Sequestration-red in fed pymt
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	Clm rcvd by dental plan but bnfts not avail. Submit to pt's medical plan.	4	Non Payment	304	Submit svcs to pt's med plan

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	Clm pending due to litigation.	21	Pending	305	Clm pending due to litigation
256	Service not payable per managed care contract.	Svc not payable per managed care contract.	4	Non Payment	306	Not payable per mngd care cont
257	The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)	Clm pending during the prem grace period, per Health Ins Exchange requirements.	21	pending	307	Clm pndng during prem grace pd
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	Clm/svc not cvrd when pt in cust/incarcerated. Fed,state,local auth may cover.	4	Non Payment	308	Clm not cvrd - pt incarcerated
A0	Patient refund amount.	Patient refund amount	19	Refund	800	Patient Refund amount
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Claim denied charges	4	Non Payment	801	Claim denied charges
A2	Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.	Contractual adjustment	4	Non Payment	802	Contractual Adjustment
A3	Medicare Secondary Payer liability met.	Medicare Secondary Payer liability met	4	Non Payment	803	MSP liability met
A4	Medicare Claim PPS Capital Day Outlier Amount.	Medicare Claim PPS Capital Day Outlier Amount	4	Non Payment	804	Medicare claim PPS Day Outlier

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
A5	Medicare Claim PPS Capital Cost Outlier Amount.	Medicare Claim PPS Capital Cost Outlier Amount	4	Non Payment	805	Medicare Claim PPS Cost Outlier
A6	Prior hospitalization or 30 day transfer requirement not met.	Prior hospitalization or 30 day transfer requirement not met	4	Non Payment	806	PriorHosp 30day transf not met
A7	Presumptive Payment Adjustment	Presumptive Payment Adjustment	4	Non Payment	807	Presumptive pymt adjustment
A8	Ungroupable DRG.	Ungroupable DRG	4	Non Payment	808	Clm Den ungroupable DRG
B1	Non-covered visits.	Non-covered visits	4	Non Payment	851	Non-Covered Visits
B2	Covered visits.	Covered visits	4	Non Payment	852	Covered Visits
B3	Covered charges.	Covered charges	4	Non Payment	853	Covered charges
B4	Late filing penalty.	Late filing penalty	15	Penalty	854	Late filing penalty
B5	Coverage/program guidelines were not met or were exceeded.	Coverage/program guidelines were not met or were exceeded	4	Non Payment	855	Guidelines not met/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.	Payment adj when performed/billed by type prv/type prv in type fac/prv specialty	4	Non Payment	856	Pymt Adj Due to Type of Prvdr
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Provider not certified/eligible to be paid for proc/service on date of service	4	Non Payment	857	Prov Not Cert for Proc on DOS

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Alternative services available and should have been utilized	4	Non Payment	858	Clm Not Covd Altrnt Srv Avail
B9	Patient is enrolled in a Hospice.	Patient is enrolled in a Hospice	4	Non Payment	859	Srvc Not Covd Pt Enrl 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.	Allowed amount reduced-a component of the basic procedure/test was paid	4	Non Payment	860	Amt Redcd Portion of Proc Pd
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	Claim/svc transferred to proper payer/processor. Claim/svc not covered	4	Non Payment	861	Clm Transfer to Proper Payer
B12	Services not documented in patients' medical records.	Services not documented in patients' medical records	4	Non Payment	862	Services not documented in MR
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	Previously paid. Payment for claim/service provided in a previous payment	4	Non Payment	863	Paymt made in prev payment
B14	Only one visit or consultation per physician per day is covered.	Payment denied-only one visit or consultation per physician per day is covered	4	Non Payment	864	Pymt Den 1 Vt per Prvdr/Day

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Service/procedure req that a qualifying service/proc be received and covered	4	Non Payment	865	Pymt Adj Proc Not Pd Separate
B16	`New Patient' qualifications were not met.	`New Patient' qualifications were not met	4	Non Payment	866	New pt qualifications 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.	Payment adjust-svc not prescribed by physician/prior to deliv, RX incomp/not curr	4	Non Payment	867	Adj Nt Prescr, RX Not Complete
B18	This procedure code and modifier was invalid on the date of service.	Procedure code and modifier invalid on date of service	4	Non Payment	868	Pymt Den Proc/Mod Code Invalid
B19	Claim/service adjusted because of the finding of a Review Organization.	Claim/service adjusted because of the finding of a Review Organization	4	Non Payment	869	Clm Adj Post Rev Org Finding
B20	Procedure/service was partially or fully furnished by another provider.	Procedure/service partially/fully furnished by another provider	4	Non Payment	870	Pymt Adj Partially other Prvdr
B21	The charges were reduced because the service/care was partially furnished by another physician.	Charges reduced - service/care partially furnished by another physician	4	Non Payment	871	Chrgs Red Partial Other Prvdr

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
B22	This payment is adjusted based on the diagnosis.	This payment is adjusted based on the diagnosis	4	Non Payment	872	Pymt Adj Based on Diagnosis
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	Proc billed not authorized per CLIA proficiency test	4	Non Payment	873	Proc Billed not Auth per CLIA
D1	Claim/service denied. Level of subluxation is missing or inadequate. Notes: Use code 16 and remark codes if necessary.	Claim/service denied. Level of subluxation is missing or inadequate	4	Non Payment	901	Clm Den Inadq Level of Sublux
D2	Claim lacks the name, strength, or dosage of the drug furnished. Notes: Use code 16 and remark codes if necessary.	Claim lacks the name, strength, or dosage of the drug furnished	4	Non Payment	902	Claim lacks drug information
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. Notes: Use code 16 and remark codes if necessary.	Claim/service denied - info indicating pat own equip requiring part/supply missing	4	Non Payment	903	Clm Den Info Pt Equip Missing
D4	Claim/service does not indicate the period of time for which this will be needed. Notes: Use code 16 and remark codes if necessary.	Claim/service does not indicate the period of time for which this will be needed	4	Non Payment	904	Period of time missing
D5	Claim/service denied. Claim lacks individual lab codes included in the test. Notes: Use code 16 and remark codes if necessary.	Claim/service denied - claim lacks individual lab codes included in the test	4	Non Payment	905	Clm Den Lacks Indvdl Lab Code

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
D6	Claim/service denied. Claim did not include patient's medical record for the service. Notes: Use code 16 and remark codes if necessary.	Claim/service denied - claim not include patient's medical record for the service	4	Non Payment	906	Clm Den No MR Copy Included
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. Notes: Use code 16 and remark codes if necessary.	Claim/service denied - claim lacks date of patient's most recent physician visit	4	Non Payment	907	Clm Den Lacks Date of RecVisit
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review'. Notes: Use code 16 and remark codes if necessary.	Claim/service denied - claim lacks indicator that `x-ray is available for review	4	Non Payment	908	Clm Den Lacks Info Xray Avail
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. Notes: Use code 16 and remark codes if necessary.	Claim/svc denied - need inv/stat cert act cost lens-disc/type intraocular lens	4	Non Payment	909	Clm Den Lacks Actual Lens Cost
D10	Claim/service denied. Completed physician financial relationship form not on file. Notes: Use code 17.	Claim/svc denied - Completed phys financial relationship form not on file	4	Non Payment	910	Clm Den Pvdr Fin. Forms NOF
D11	Claim lacks completed pacemaker registration form. Notes: Use code 17.	Claim lacks completed pacemaker registration form	4	Non Payment	911	Clm Lacks Pcmkr Reg Form
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. Notes: Use code 17.	Claim/svc denied - need ident who performed the purchased diag test/amt charged	4	Non Payment	912	Clm Den No Idtfr Who did DXtst

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. Notes: Use code 17.	Claim/svc denied - performed by fac/supplier where order/refer phys has finan int	4	Non Payment	913	Clm Den Pvdr has Fin Interest
D14	Claim lacks indication that plan of treatment is on file. Notes: Use code 17.	Claim lacks indication that plan of treatment is on file	4	Non Payment	914	Clm Lacks TX Plan on File
D15	Claim lacks indication that service was supervised or evaluated by a physician. Notes: Use code 17.	Claim lacks indication that service was supervised or evaluated by a physician	4	Non Payment	915	Clm Lacks Sprvs MD Info
D16	Claim lacks prior payer payment information. Notes: Use code 16 with appropriate claim payment remark code [N4].	Claim lacks prior payment information	4	Non Payment	900	Clm Lacks Prior Pymt Info
D17	Claim/Service has invalid non-covered days. Notes: Use code 16 with appropriate claim payment remark code.	Claim/service has invalid non-covered days	4	Non Payment	927	Clm/Svc invld noncoverd days
D18	Claim/Service has missing diagnosis information. Notes: Use code 16 with appropriate claim payment remark code.	Claim/service has missing diagnosis information	4	Non Payment	928	Clm/Svc missing DX info
D19	Claim/Service lacks Physician/Operative or other supporting documentation. Notes: Use code 16 with appropriate claim payment remark code.	Claim/service lacks physician/operative or other supporting documentation	4	Non Payment	929	Clm Lacks Supporting Dcmnt

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
D20	Claim/Service missing service/product information. Notes: Use code 16 with appropriate claim payment remark code.	Claim/service missing service/product information	4	Non Payment	970	Clm/Svc miss svc/prod info
D21	This (these) diagnosis(es) is (are) missing or are invalid.	This (these) diagnosis(es) is/are missing or are invalid	4	Non Payment	971	DX(s) missing or invalid
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only).	Reimbursement adjust - reasons to be provided in separate correspondence (WC only)	4	Non Payment	972	WC Pymt Adj Reason issue separ
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	Dual elig pt covered by Medicare Part D per Medicare Retro-Eligibility	4	Non Payment	973	Other primary coverage
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	State-mandated requirement for property/casualty, see claim payment remark codes	22	General Information	401	ST-mandated rqrmt for property
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. To be used for Workers' Compensation only.	Not a work related injury/illness and not the liability of the WC carrier	4	Non Payment	402	Not work related inj/illness

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only.	Worker's Comp case settled. Pt is responsible.	4	Non Payment	403	WC case settled, pt resp
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. To be used for Workers' Compensation only.	Worker's Comp case adjudicated as non-compensable. Payer not liable for clm/svc.	4	Non Payment	404	WC case adjudicated as non-WC
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	Based on payer reasonable/customary fees. No max allow defined by fee arrgmt.	4	Non Payment	405	Based on payer reas & cust fee
P6	Based on entitlement to benefits. To be used for Property and Casualty only.	Based on entitlement to benefits	4	Non Payment	406	Based on entitlement to bnfts
P7	The applicable fee schedule/database doesn't contain the billed code. Resubmit bill with appropriate fee schedule/database code(s) that best describe service(s) provided and supporting documents if req.	The applicable fee sched/fee db does not contain billd code. Resub crrctd bill.	22	General Information	407	Resub w/correct proc code
P8	Claim is under investigation. To be used for Property and Casualty only.	Claim is under investigation.	22	General Information	408	Clm is under investigation
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	No available/correlating CPT/HCPCS to describe this service	4	Non Payment	409	No CPT/HCPCS to describe svc
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	Payment reduced to zero due to litigation.	4	Non Payment	410	Zero pmt due to litigation

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	The disposition of this claim/service is pending due to litigation.	21	Pending	411	Clm pending due to litigation
P12	Workers' compensation jurisdictional fee schedule adjustment. To be used for Workers' Compensation only.	WC jurisdictional fee schedule adjustment.	4	Non Payment	412	WC fee schedule adjustment
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Workers' Compensation only.	Payment red or denied based on WC jurisdictional regulations or pymt policies.	4	Non Payment	413	Pmt reduced due to WC policies
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. To be used for Property and Casualty only.	Benefit for this svc included in pymt for another svc performed on the same day.	4	Non Payment	414	Pmt incl w/pmt for other svc
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	WC Medical Treatment Guideline Adjustment	4	Non Payment	415	WC Med Trtmt Guideline adjstmt
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	Medical provider not auth'd/certified to provide trtmt to injured workers.	4	Non Payment	416	Med prov not auth'd for WC
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	Referral not auth'd by attending physician.	15	Penalty	417	Referral not auth'd by attndng

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	Proc not listed in the jurisdiction fee schedule. Allowance made for comp svc.	4	Non Payment	418	Proc not listed/comp svc allwd
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	Proc has a relative value of zero in the jurisdictional fee sched, no pymt due.	4	Non Payment	419	No pymt due,proc fee is zero
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	Svc not pd under outpatient facility fee schedule.	4	Non Payment	420	Svc not pd under oupt fee schd
P21	Pymnt den based on Med Pymnts Coverage or Personal Inj Protection Ben jurisdictional regulations or payment policies, use only if no other code applicable. Used for Property & Casualty Auto only.	Payment den based on med payments coverage or personal injury protection bnfts.	4	Non Payment	421	TPL Payment denied-MPC/PIP
P22	Pymnt adjust based on Medical Pymnts Cov or Personal Injury Protection Ben jurisdictional regulations or pymnt policies, use only if no other code is app. Used for Property and Casualty Auto only.	Payment adjusted based on medical pymts cov or pers injury protection bnfts.	4	Non Payment	422	TPL Payment adjusted-MPC/PIP
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.	Med Payments Coverage or Pers Injury Protection Benefits fee sched adjustment.	4	Non Payment	423	TPL Fee Sch Adjust-MPC/PIP

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
W1	Workers Compensation State Fee Schedule Adjustment. Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	WC State fee schedule adjustment/WC jurisdiction fee schedule adjustment	3	Write Off	15	Wrkrs comp State Fee Sched Adj
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	Payment reduced/denied - WC jurisdictional regulations or payment policies	4	Non Payment	822	WC Pymt Den, no other code app
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. For use by Property and Casualty only.	Benefit for this svc included in pymt for another svc performed on the same day.	4	Non Payment	823	Pmt incl w/pmt for other svc
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	WC Medical Treatment Guideline Adjustment	4	Non Payment	824	WC Med Trtmt Guideline adjstmt

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	Medical provider not auth'd/certified to provide trtmt to injured workers.	4	Non Payment	825	Med prov not auth'd for WC
W6	Referral not authorized by attending physician per regulatory requirement.	Referral not auth'd by attending physician.	15	Penalty	826	Referral not auth'd by attndng
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	Proc not listed in the jurisdiction fee schedule. Allowance made for comp svc.	22	General Information	827	Proc not listed/comp svc allwd
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	Proc has a relative value of zero in the jurisdictional fee sched, no pymt due.	22	General Information	828	No pymt due,proc fee is zero
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	Svc not pd under outpatient facility fee schedule.	4	Non Payment	829	Svc not pd under oupt fee schd
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	Payment den based on med payments coverage or personal injury protection bnfts.	4	Non Payment	841	Payment denied
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	Payment adjusted based on medical pymts cov or pers injury protection bnfts.	4	Non Payment	842	Payment adjusted

SAR Code	Long Description	Short Description	Adj-Cat Code	Adjustment Category	RPMS Adj-Reason Code	Adjustment Reason
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment.	Med Payments Coverage or Pers Injury Protection Benefits fee sched adjustment.	22	General Information	843	Fee schedule adjustment

Acronym List

3P	Third Party
A/R	Accounts Receivable
ERA	Electronic Remittance Advice
IHS	Indian Health Service
LIS	Low Income Subsidy
NBR	Non-Beneficiary Payment Report
RPMS	Resource and Patient Management System
SAR	Standard Adjustment Reason
TPB	Third Party Billing
UFMS	Unified Financial Management System

Contact Information

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