# Indian Health Service HIPAA
## Business Office Accounts Receivable RPMS Adjustment Categories
## Claim Adjustment Reason Codes Mapping - 09/21/02 - Final

Green box denotes no changes to code  Changes Made by Linda on 9/20/02

| | 835 | | RPMS | | RPMS |
|---|---|---|---|---|---|
| | **Code** | **Description** | **Adjustment Category** | **Adjustment Reason** | **New Adjustment Reason** |
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| X | 1 | Deductible Amount | 13 Deductible | 29 Deductible | |
| X | 2 | Coinsurance Amount | 14 Co-Pay | 27 Co-payment | 602 Coinsurance |
| X | 3 | Co-payment Amount | 14 Co-pay | 27 Co-payment | |
| X | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | 21 Pending (NEW) | 604 Coding Error | |
| X | 5 | The procedure code/bill type is inconsistent with the place of service. | 21 Pending (NEW) | 605 Coding Error | |
| X | 6 | The procedure code is inconsistent with the patient's age. | 21 Pending (NEW) | 606 Coding Error | |
| X | 7 | The procedure code is inconsistent with the patient's gender. | 21 Pending (NEW) | 607 Coding Error | |
| X | 8 | The procedure code is inconsistent with the provider type. | 21 Pending (NEW) | 608 Coding Error | |
| X | 9 | The diagnosis is inconsistent with the patient's age. | 21 Pending (NEW) | 609 Coding Error | |
| X | 10 | The diagnosis is inconsistent with the patient's gender. | 21 Pending (NEW) | 610 Coding Error | |
| X | 11 | The diagnosis is inconsistent with the procedure. | 21 Pending (NEW) | 611 Coding Error | |
| X | 12 | The diagnosis is inconsistent with the provider type. | 21 Pending (NEW) | 612 Coding Error | |
| X | 13 | The date of death precedes the date of service. | 21 Pending (NEW) | 613 Death Precedes DOS (NEW) | |
| X | 14 | The date of birth follows the date of service. | 21 Pending (NEW) | 614 Birth Follows DOS (NEW) | |
| X | 15 | Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. | 21 Pending (NEW) | 615 Info not received/sufficient | |
| X | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | 21 Pending (NEW) | 616 Missing Data | |
| X | 17 | Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. | 21 Pending (NEW) | 617 Info. Not received/sufficient | |
| X | 18 | Duplicate claim/service. | 3 Write Off | 135 Billed in error | |
| X | 19 | Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. | 21 Pending (NEW) | 619 Other TPL | |
| X | 20 | Claim denied because this injury/illness is covered by the liability carrier. | 21 Pending (NEW) | 620 Other TPL | |
| X | 21 | Claim denied because this injury/illness is the liability of the no fault carrier. | 21 Pending (NEW) | 621 Other TPL | |
| X | 22 | Payment adjusted because this care may be covered by another payer per coordination of benefits. | 21 Pending (NEW) | 622 Other Primary Coverage | |
| X | 23 | Payment adjusted because charges have been paid by another payer. | 4 Non Payment | 165 Other primary coverage | 623 Other Primary Coverage-Oth Pay |
| X | 24 | Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. | 4 Non Payment | 168 Over contracted amount | 624 Over contracted amount-CAP |
| X | 25 | Payment denied. Your Stop loss deductible has not been met. | 4 Non Payment | 625 Stop Loss Deduct Not Met (NEW) | |
| X | 26 | Expenses incurred prior to coverage. | 4 Non Payment | 125 Outside coverage dates | 626 Outside coverage dates-Prior |
| X | 27 | Expenses incurred after coverage terminated. | 4 Non Payment | 125 Outside coverage dates | 627 Oustide coverage dates-After |

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| X | 28 | Coverage not in effect at the time the service was provided. | 4 Non Payment | 125 Outside coverage dates | 628 Outside coverage dates-Cov/DOS |
| X | 29 | The time limit for filing has expired. | 4 Non Payment | 134 Beyond Filing Limit | |
| X | 30 | Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. | 4 Non Payment | 630 PT Not Met Reqd Reqmnts (NEW) | |
| X | 31 | Claim denied as patient cannot be identified as our insured. | 4 Non Payment | 166 No elig. found | |
| X | 32 | Our records indicate that this dependent is not an eligible dependent as defined. | 4 Non Payment | 166 No elig. found | 632 No elig. Found-dep not elig |
| X | 33 | Claim denied. Insured has no dependent coverage. | 4 Non Payment | 166 No elig. found | 633 No elig. Found-no dep cov |
| X | 34 | Claim denied. Insured has no coverage for newborns. | 4 Non Payment | 17 Eligibility denied | |
| X | 35 | Benefit maximum has been reached. | 4 Non Payment | 167 Maximum benefits | |
| | 36 | Balance does not exceed co-payment amount. | 4 Non Payment | 636 Bal Does not Exceed COPAY (NEW) | |
| | 37 | Balance does not exceed deductible. | 4 Non Payment | 637 Bal Does not Exceed DEDUCT (NEW) | |
| X | 38 | Services not provided or authorized by designated (network) providers. | 4 Non Payment | 638 Provider Not in Network (NEW) | |
| X | 39 | Services denied at the time authorization/pre-certification was requested. | 4 Non Payment | 639 Srvces Denied precert rqstd | |
| X | 40 | Charges do not meet qualifications for emergent/urgent care. | 4 Non Payment | 169 Not medically necessary | 640 Not medically necessary-ER/Urg |
| X | 41 | Discount agreed to in Preferred Provider contract. | 4 Non Payment | 168 Over contracted amount | |
| X | 42 | Charges exceed our fee schedule or maximum allowable amount. | 4 Non Payment | 21 Over allowable amount | |
| X | 43 | Gramm-Rudman reduction. | 4 Non Payment | 643 Gramm-Rudman reduction | |
| X | 44 | Prompt-pay discount. | 4 Non Payment | 644 Prompt Pay Discount (NEW) | |
| X | 45 | Charges exceed your contracted/ legislated fee arrangement. | 4 Non Payment | 168 Over contracted amount | 645 Over contracted amount-Exceed |
| X | 46 | This (these) service(s) is (are) not covered. | 4 Non Payment | 122 Non covered service | |
| X | 47 | This (these) diagnosis(es) is (are) not covered, missing, or are invalid. | 21 Pending (NEW) | 647 Non covered service | |
| X | 48 | This (these) procedure(s) is (are) not covered. | 4 Non Payment | 122 Non covered service | 648 Non covered service-Procedure |
| X | 49 | These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. | 4 Non Payment | 20 Routine exams | |
| X | 50 | These are non-covered services because this is not deemed a `medical necessity' by the payer. | 4 Non Payment | 169 Not medically necessary | |
| X | 51 | These are non-covered services because this is a pre-existing condition | 4 Non Payment | 19 Pre existing condition | |
| X | 52 | The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. | 4 Non Payment | 178 Incorrect provider type | |
| X | 53 | Services by an immediate relative or a member of the same household are not covered. | 4 Non Payment | 122 Non covered service | 653 Non covered service-Relative |
| X | 54 | Multiple physicians/assistants are not covered in this case . | 4 Non Payment | 178 Incorrect provider type | 654 Incorrect Provider Type |
| X | 55 | Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer. | 21 Pending (NEW) | 655 Noncovered Service | |
| X | 56 | Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer. | 21 Pending (NEW) | 656 Noncovered Service | |
| X | 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. | 21 Pending (NEW) | 657 Info. Not received/sufficient | |

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| X | 58 | Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. | 21 Pending (NEW) | 658 Non Covered Service | |
| X | 59 | Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. | 4 Non Payment | 21 Over allowable amount | 659 Over allowable amount |
| X | 60 | Charges for outpatient services with this proximity to inpatient services are not covered. | 4 Non Payment | 122 Noncovered Service | 660 Noncovered Service-Out/In |
| X | 61 | Charges adjusted as penalty for failure to obtain second surgical opinion. | 21 Pending (NEW) | 661 No Prior Approval | |
| X | 62 | Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. | 15 Penalty | 662 No Prior Approval | 92 No Prior Approval (already exists) |
| | 63 | Correction to a prior claim. | 21 Pending (NEW) | 663 Correction to Prior Claim (NEW) | |
| | 64 | Denial reversed per Medical Review. | 22 Gen Information (NEW) | 664 Denial reversed per Med Review | |
| | 65 | Procedure code was incorrect. This payment reflects the correct code. | 21 Pending (NEW) | 665 Coding Error | |
| X | 66 | Blood Deductible. | 13 Deductible | 29 Deductible | 666 Blood Deductible |
| | 67 | Lifetime reserve days. (Handled in QTY, QTY01=LA) | 4 Non Payment | 167 Maximum benefits | 667 Maximum benefits-life res days |
| | 68 | DRG weight. (Handled in CLP12) | 16 Grouper Allowance | 93 DRG | |
| X | 69 | Day outlier amount. | 4 Non Payment | 669 Day Outlier Amount (NEW) | |
| X | 70 | Cost outlier - Adjustment to compensate for additonal costs. | 4 Non Payment | 670 Cost Outlier Adj (NEW) | |
| | 71 | Primary Payer amount. | 4 Non Payment | 165 Other primary coverage | |
| | 72 | Coinsurance day. (Handled in QTY, QTY01=CD) | 14 Co-Pay | 27 Co-pay | 672 Coinsurance-Day |
| | 73 | Administrative days. | 4 Non Payment | 673 Administrative Days (NEW) | |
| X | 74 | Indirect Medical Education Adjustment. | 4 Non Payment | 674 Indirect Med Ed Adj (NEW) | |
| X | 75 | Direct Medical Education Adjustment. | 4 Non Payment | 675 Direct Medical Ed Adj (NEW) | |
| X | 76 | Disproportionate Share Adjustment. | 4 Non Payment | 676 Disproportionate Share Adj (NEW) | |
| | 77 | Covered days. (Handled in QTY, QTY01=CA) | 4 Non Payment | 677 Covered Days (NEW) | |
| X | 78 | Non-Covered days/Room charge adjustment. | 4 Non Payment | 122 Non covered service | 678 Noncovered Service-NCD/Room |
| | 79 | Cost Report days. (Handled in MIA15) | 4 Non Payment | 679 Cost Report Days (NEW) | |
| | 80 | Outlier days. (Handled in QTY, QTY01=OU) | 4 Non Payment | 680 Outlier Days (NEW) | |
| | 81 | Discharges. | 4 Non Payment | 681 Discharges (NEW) | |
| | 82 | PIP days. | 4 Non Payment | 682 PIP days (NEW) | |
| | 83 | Total visits. | 4 Non Payment | 683 Total visits (NEW) | |
| | 84 | Capital Adjustment. (Handled in MIA) | 4 Non Payment | 684 Capital Adjustment (NEW) | |
| X | 85 | Interest amount. | 4 Non Payment | 685 Interest Amount (NEW) | |
| X | 86 | Statutory Adjustment. | 4 Non Payment | 686 Statutory Adjustment (NEW) | |
| X | 87 | Transfer amount. | 4 Non Payment | 687 Transfer Amount (NEW) | |
| X | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | 21 Pending (NEW) | 688 Prior Overpayment (NEW) | |
| X | 89 | Professional fees removed from charges. | 4 Non Payment | 689 Professional Fee Removed (NEW) | |
| X | 90 | Ingredient cost adjustment. | 4 Non Payment | 690 Ingredient Cost Adj (NEW) | |
| X | 91 | Dispensing fee adjustment. | 3 Write Off | 691 Dispensing Fee Adj (NEW) | |
| | 92 | Claim Paid in full. | 22 General Information (NEW | 692 Claim Paid in Full | |
| X | 93 | No Claim level Adjustments. | 22 General Information (NEW | 693 No Claim level Adjustments | |
| X | 94 | Processed in Excess of charges. | 16 Grouper Allowance | 694 Procssed in Excess of Chrgs (NEW) | |
| X | 95 | Benefits adjusted. Plan procedures not followed. | 4 Non Payment | 21 Over allowable amount | 695 Over allowable amount |
| X | 96 | Non-covered charge(s). | 4 Non Payment | 122 Noncovered Service | 696 Non covered service-charge |
| X | 97 | Payment is included in the allowance for another service/procedure. | 4 Non Payment | 697 Bundled to anoth procedure (NEW) | |
| | 98 | The hospital must file the Medicare claim for this inpatient non-physician service. | 21 Pending (NEW) | 698 Other primary coverage | |
| | 99 | Medicare Secondary Payer Adjustment Amount. | 4 Non Payment | 165 Other primary coverage | 699 Other Primary Coverage-MCR Sec |
| X | 100 | Payment made to patient/insured/responsible party. | 4 Non Payment | 23 Ins Check kept by patient | |

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| X | 101 | Predetermination: anticipated payment upon completion of services or claim adjudication. | 21 Pending (NEW) | 701 Predetermination | |
| X | 102 | Major Medical Adjustment. | 4 Non Payment | 702 Major Medical Adj (NEW) | |
| | 103 | Provider promotional discount (e.g., Senior citizen discount). | 4 Non Payment | 703 Provider Promo Discount (NEW) | |
| | 104 | Managed care withholding. | 4 Non Payment | 168 Over contracted amount | 704 Over contracted amount-mg care |
| | 105 | Tax withholding. | 4 Non Payment | 705 Tax Withholding (NEW) | |
| | 106 | Patient payment option/election not in effect. | 4 Non Payment | 706 Pt pymt option/election not in effct (NEW) | |
| | 107 | Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim. | 21 Pending (NEW) | 707 Missing data | |
| | 108 | Payment reduced because rent/purchase guidelines were not met. | 4 Non Payment | 708 Pymt Reduced-guidelines (NEW) | |
| | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | 4 Non Payment | 17 Elig. Denied | 709 Eligibility Denied |
| | 110 | Billing date predates service date. | 21 Pending (NEW) | 710 Billing Date predates DOS (NEW) | |
| | 111 | Not covered unless the provider accepts assignment. | 4 Non Payment | 122 Noncovered Service | 711 Noncovered Service-PRV accept |
| | 112 | Payment adjusted as not furnished directly to the patient and/or not documented. | 4 Non Payment | 180 Documentation required | |
| | 113 | Payment denied because service/procedure was provided outside the United States or as a result of war. | 4 Non Payment | 122 Noncovered Service | 713 Noncovered Service-out US/War |
| | 114 | Procedure/product not approved by the Food and Drug Administration. | 4 Non Payment | 714 Not approved by FDA (NEW) | |
| | 115 | Payment adjusted as procedure postponed or canceled. | 4 Non Payment | 122 Noncovered Service | 715 Noncovered Service-cncl/post |
| | 116 | Payment denied. The advance indemnification notice signed by the patient did not comply with requirements. | 4 Non Payment | 184 Info not received/sufficient | 716 Info not Received/Sufficient |
| | 117 | Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care. | 4 Non Payment | 122 Noncovered Service | 717 Noncovered Service-Transport |
| | 118 | Charges reduced for ESRD network support. | 4 Non Payment | 122 Noncovered Service | 718 Noncovered Service-ESRD |
| | 119 | Benefit maximum for this time period has been reached. | 4 Non Payment | 167 Maximum benefits | 719 Maximum benefits-for time per |
| | 120 | Patient is covered by a managed care plan. | 4 Non Payment | 165 Other primary coverage | 720 Other Primary Coverage-mg care |
| | 121 | Indemnification adjustment. | 4 Non Payment | 721 Indemnification Adj (NEW) | |
| | 122 | Psychiatric reduction. | 4 Non Payment | 722 Psychiatric Reduction (NEW) | |
| | 123 | Payer refund due to overpayment. | 22 Gen Information (NEW) | 723 Payer refund due to ovrpymt (NEW) | |
| | 124 | Payer refund amount - not our patient. | 22 Gen Information (NEW) | 724 Payer refund Amt - not out pt (NEW) | |
| | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | 21 Pending (NEW) | 725 Pymt adj due to billing errors (NEW) | |
| | 126 | Deductible -- Major Medical | 13 Deductible | 29 Deductible | 726 Deductible-Major Medical |
| | 127 | Coinsurance -- Major Medical | 14 Co-Pay | 727 Coinsurance - Major Medical | |
| | 128 | Newborn's services are covered in the mother's Allowance. | 4 Non Payment | 165 Other primary coverage | 728 Other Primary Coverage-Newborn |
| | 129 | Payment denied - Prior processing information appears incorrect. | 4 Non Payment | 164 Info not received/sufficient | |
| | 130 | Claim submission fee. | 4 Non Payment | 141 Processing fee | 730 Processing Fee-Claim Submit |
| | 131 | Claim specific negotiated discount. | 4 Non Payment | 141 Processing fee | 731 Processing Fee-Discount |
| | 132 | Prearranged demonstration project adjustment. | 4 Non Payment | 732 Pre-Demo Project Adj (NEW) | |
| | 133 | The disposition of this claim/service is pending further review. | 21 Pending (NEW) | 733 Pending Further Review | |
| | 134 | Technical fees removed from charges. | 4 Non Payment | 122 Noncovered Service | 734 Noncovered Service-Tech Fee |
| | 135 | Claim denied. Interim bills cannot be processed. | 4 Non Payment | 735 Denied do not proc Intrm bill (NEW) | |
| | 136 | Claim Adjusted. Plan procedures of a prior payer were not followed. | 4 Non Payment | 736 Prior Payer P&P not followed (NEW) | |
| | | Payment/Reduction for Regulatory Surcharges, Assessments, | | | |

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| | 138 | Claim/service denied. Appeal procedures not followed or time limits not met. | 4 Non Payment | 738 Appeal Procedures not followed (NEW) | |
| | 139 | Contracted funding agreement - Subscriber is employed by the provider of services. | 4 Non Payment | 168 Over contracted amount | 739 Over contracted amount-Employee |
| | 140 | Patient/Insured health identification number and name do not match. | 21 Pending (NEW) | 740 Pt ID# & Name do not match (NEW) | |
| | 141 | Claim adjustment because the claim spans eligible and ineligible periods of coverage. | 4 Non Payment | 125 Outside coverage dates | |
| | 142 | Claim adjusted by the monthly Medicaid patient liability amount. | 4 Non Payment | 168 Over contracted amount | 742 Over Contracted Amount-MCD Pat |
| | 143 | Portion of payment deferred. | 21 Pending (NEW) | 743 Portion of Payment deferred (NEW) | |
| | 144 | Incentive adjustment, e.g. preferred product/service. | 4 Non Payment | 744 Incentive Adjustment (NEW) | |
| | A0 | Patient refund amount. | 19 Refund | 800 Patient Refund amount (NEW) | |
| | A1 | Claim denied charges. | 4 Non Payment | 801 Claim denied charges (NEW) | |
| | 2 | Contractual adjustment. | 4 Non Payment | 168 Over contracted amount | 802 Over contracted amount-Ctr Adj |
| | A3 | Medicare Secondary Payer liability met. | 4 Non Payment | 803 MSP liability met | |
| | A4 | Medicare Claim PPS Capital Day Outlier Amount. | 4 Non Payment | 804 Medicare claim PPS Day Outlier | |
| | A5 | 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. | 4 Non Payment | 806 Prior hosp or 30 day transfer not met | |
| | A7 | Presumptive Payment Adjustment | 4 Non Payment | 807 Presumptive pymt adjustment | |
| | A8 | Claim denied; ungroupable DRG | 4 Non Payment | 808 Ungroupable DRG | |
| | B1 | Non-covered visits. | 4 Non Payment | 122 Noncovered Service | 851 Noncovered Service-Visit |
| | B2 | Covered visits. | 4 Non Payment | 852 Non-covered visits | |
| | B3 | Covered charges. | 4 Non Payment | 853 Covered charges | |
| | B4 | Late filing penalty. | 15 Penalty | 854 Late filing penalty (NEW) | |
| | B5 | Payment adjusted because 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. | 4 Non Payment | 178 Incorrect provider type | 856 Incorrect Provider Type |
| | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | 4 Non Payment | 178 Incorrect provider type | 857 Incorrect Provider Type |
| | B8 | Claim/service not covered/reduced because alternative services were available, and should have been utilized. | 4 Non Payment | 165 Other primary coverage | 858 Other Primary Coverage-alt svc |
| | B9 | Services not covered because the patient is enrolled in a Hospice. | 4 Non Payment | 122 Noncovered Service | 859 Noncovered Service-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. | 4 Non Payment | 21 Over allowable amount | 860 Over allowable amount |
| | B11 | The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. | 4 Non Payment | 165 Other primary coverage | 861 Other Primary Coverage-not cov |
| | B12 | Services not documented in patients' medical records. | 21 Pending (NEW) | 862 Services not documented in MR | |
| | B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment. | 21 Pending (NEW) | 863 Paymt made in prev payment | |
| | B14 | Payment denied because only one visit or consultation per physician per day is covered. | 4 Non Payment | 122 Noncovered Service | 864 Noncovered Service-one/day |
| | B15 | Payment adjusted because this procedure/service is not paid separately. | 4 Non Payment | 122 Noncovered Service | 865 Noncovered Service-Not PD Sep |
| | | Payment adjusted because `New Patient' qualifications were | | | |

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| | 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. | 4 Non Payment | 867 Not prescr by MD,RX incmplete | |
| | B18 | Payment denied because this procedure code/modifier was invalid on the date of service or claim submission. | 21 Pending (NEW) | 868 Proc code/modifer invalid | |
| | B19 | Claim/service adjusted because of the finding of a Review Organization. | 4 Non Payment | 169 Not medically necessary | 869 Not medically necessary-Rv Fnd |
| | B20 | Payment adjusted because procedure/service was partially or fully furnished by another provider. | 4 Non Payment | 178 Incorrect provider type | 870 Incorrect Provider Type |
| | B21 | The charges were reduced because the service/care was partially furnished by another physician. | 4 Non Payment | 178 Incorrect provider type | 871 Incorrect Provider Type |
| | B22 | This payment is adjused based on the diagnosis. | 21 Pending (NEW) | 872 Adjusted based on diagnosis | |
| | B23 | Payment denied because this provider has failed an aspect of a proficiency testing program. | 21 Pending (NEW) | 873 Provider failed proficiency test | |
| | D1 | Claim/service denied. Level of subluxation is missing or inadequate. | 21 Pending (NEW) | 901 Level of subluxation inadequate | |
| | D2 | Claim lacks the name, strength, or dosage of the drug furnished. | 21 Pending (NEW) | 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. | 21 Pending (NEW) | 903 Info on patient equipment missing | |
| | D4 | Claim/service does not indicate the period of time for which this will be needed. | 21 Pending (NEW) | 904 Period of time missing | |
| | D5 | Claim/service denied. Claim lacks individual lab codes included in the test. | 21 Pending (NEW) | 905 Coding Error | |
| | D6 | Claim/service denied. Claim did not include patient's medical record for the service. | 21 Pending (NEW) | 906 Missing Field | |
| | D7 | Claim/service denied. Claim lacks date of patient's most recent physician visit. | 21 Pending (NEW) | 907 Info not received/sufficient | |
| | D8 | Claim/service denied. Claim lacks indicator that `x-ray is available for review.' | 21 Pending (NEW) | 908 Info not received/sufficient | |
| | 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. | 21 Pending (NEW) | 909 Info not received/sufficient | |
| | D10 | Claim/service denied. Completed physician financial relationship form not on file. | 21 Pending (NEW) | 910 Info not received/sufficient | |
| | D11 | Claim lacks completed pacemaker registration form. | 21 Pending (NEW) | 911 Info not received/sufficient | |
| | D12 | Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. | 21 Pending (NEW) | 912 Info not received/sufficient | |
| | D13 | Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. | 21 Pending (NEW) | 913 Financial Interest - Doctor (NEW) | |
| | D14 | Claim lacks indication that plan of treatment is on file. | 21 Pending (NEW) | 914 Documentation required | |
| | D15 | Claim lacks indication that service was supervised or evaluated by a physician. | 4 Non Payment | 915 Documentation required | |
| | W1 | Workers Compensation State Fee Schedule Adjustment | Write Off | 15 Sliding Fee | |

X As found in Medicare 835 V3041.4A Mapping