69027441408 5793365.5178571 35254632.849057 34361708095 127970712624 25912034.537313 5543906.3333333 15805331.982456 41022097.8 5815235.5 16604186450 38765278.888889 19724366.107143 77164432351 57035130560 29796469.967213 50822952741 22072346.404494 31234089105 76099968252 123761311806 99896382026 19726252.139535 1494073.7171717

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N690Alert: This reversal is due to a provider submitted appeal. N355Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. Refer to item 19 on the HCFA-1500. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. Append RA modifier to claim Appeal if denied and provided for lost, stolen, or irreparably damaged (specific incident) with documentation from beneficiary statement, police report, fire report, or insurance claim information, etc. People who choose to work from home must be self-starters who are highly motivated and can focus on the task at hand. MA75Missing/incomplete/invalid patient or authorized representative signature. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.Start: 03/01/2014 N721This service is only covered when performed as part of a clinical trial.Start: 03/01/2014 N722Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.Start: 03/01/2014 N723Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.Start: 03/01/2014 N724Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.Start: 03/01/2014 N725A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.Start: 03/01/2014 N726A conditional payment is not allowed.Start: 03/01/2014 N727A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.Start: 03/01/2014 N728A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.Start: 03/01/2014 N729Missing patient medical/dental record for this service.Start: 11/01/2014 N730Incomplete/invalid patient medical/dental record for this service.Start: 11/01/2014 N731Incomplete/Invalid mental health assessment.Start: 11/01/2014 N732Services performed at an unlicensed facility are not reimbursable.Start: 11/01/2014 N733Regulatory surcharges are paid directly to the state.Start: 11/01/2014 N734The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.Start: 11/01/2014 N735Adjustment without review of medical/dental record because the requested records were not received or were not received timely.Start: 03/01/2015 | Stop: 01/01/2016 N736Incomplete/invalid Sleep Study Report.Start: 03/01/2015 N737Missing Sleep Study Report.Start: 03/01/2015 N738Incomplete/invalid Vein Study Report.Start: 03/01/2015 N739Missing Vein Study Report.Start: 03/01/2015 N740The member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.Start: 03/01/2015 N741This is a site neutral payment.Start: 03/01/2015 N742Alert: This claim was processed based on one or more ICD-9 codes. N2This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.Start: 01/01/2000 N3Missing consent form. M27Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. N42Missing mental health assessment.Start: 01/01/2000 | Last Modified: 11/01/2014 N43Bed hold or leave days exceeded.Start: 01/01/2000 N44Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority. MA10Alert: The patient's payment was in excess of the amount owed. N413This service is allowed 2 times in a benefit year. MA07Alert: The claim information has also been forwarded to Medicaid for review. M34Claim lacks the CLIA certification number. Please submit a separate claim for each interpreting physician.Start: 01/01/1997 M66Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. M10Equipment purchases are limited to the first or the tenth month of medical necessity.Start: 01/01/1997 M11DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.Start: 01/01/1997 M12Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.Start: 01/01/1997 M13Only one initial visit is covered per specialty per medical group. Remark Code: M3 Equipment is the same or similar to equipment already being used. M50Missing/incomplete/invalid revenue code(s). Resubmit a new claim, not a replacement claim.Start: 10/31/2002 N143The patient was not in a hospice program during all or part of the service dates billed.Start: 10/31/2002 N144The rate changed during the dates of service billed.Start: 10/31/2002 N145Missing/incomplete/invalid provider identifier for this place of service.Start: 10/31/2002 | Stop: 06/02/2005 N146Missing screening document. N442Payment based on an alternate fee schedule.Start: 07/01/2008 N443Missing/incomplete/invalid total time or begin/end time.Start: 07/01/2008 N444Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.Start: 07/01/2008 N445Missing document for actual cost or paid amount.Start: 07/01/2008 N446Incomplete/invalid document for actual cost or paid amount.Start: 07/01/2008 N447Payment is based on a generic equivalent as required documentation was not provided.Start: 07/01/2008 N448This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. N184Rebill technical and professional components separately.Start: 02/28/2003 N185Alert: Do not resubmit this claim/service. They cannot be billed separately as outpatient services.Start: 01/31/2002 N108Missing/incomplete/invalid upgrade information. This is the maximum approved under the fee schedule for this item or service.Start: 01/01/1997 M105Information supplied does not support a break in therapy. You are required by law to accept assignment for these types of claims. M124Missing indication of whether the patient owns the equipment that requires the part or supply. MA45Alert: As previously advised, a portion or all of your payment is being held in a special account. Your failure to correct the laboratory certification information will result in a denial of payment in the near future. MA20Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence. M71Total payment reduced due to overlap of tests billed.Start: 01/01/1997 M72Did not enter full 8-digit date (MM/DD/CCYY). M89Not covered more than once under age 40.Start: 01/01/1997 M90Not covered more than once in a 12 month period.Start: 01/01/1997 M91Lab procedures with different CLIA certification numbers must be billed on separate claims.Start: 01/01/1997 M92Services subjected to review under the Home Health Medical Review Initiative.Start: 01/01/1997 | Stop: 08/01/2004 M93Information supplied supports a break in therapy. The member will receive an Explanation of Benefits electronically or in the mail. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.Start: 08/01/2004 N219Payment based on previous payer's allowed amount.Start: 08/01/2004 N220Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute. Resubmit separate claims. Ask how they handle employees that work remotely.Job OutlookMedical coding is a growing field. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice. MA94Did not enter the statement 'Attending physician not hospice employee' on the claim form to certify that the rendering physician is not an employee of the hospice. as applicable If providing prior to end of RUL for change in medical condition, may obtain an ABN Appeal if denied and provided for change in medical condition with medical records to substantiate need If appeal is upheld/denied, write off amount from AR Are there rental items billing as upgrades and are they correctly billing each month with appropriate modifiers? Review your records for any wrongfully collected coinsurance. N509Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. M132Missing pacemaker registration form. M118Letter to follow containing further information. N800Only one service date is allowed per claim.Start: 03/01/2018 N801Services performed in a Medicare participating or CAH facility under a self-insured tribal Group Health Plan, in accordance with Federal Regulation 42 CFR 136.Start: 03/01/2018 N802This claim/service is not payable under our service area. Claim not on file.Start: 01/01/2000 N6Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B. MA122Missing/incomplete/invalid initial treatment date. N365This procedure code is not payable. N782Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. N76Missing/incomplete/invalid number of riders. N646Reimbursement has been adjusted based on the guidelines for an assistant.Start: 07/15/2013 N647Adjusted based on diagnosis-related group (DRG).Start: 07/15/2013 N648Adjusted based on Stop Loss.Start: 07/15/2013 N649Payment based on invoice.Start: 07/15/2013 N650This policy was not in effect for this date of loss. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.Start: 07/01/2012 N558This claim/service is not payable under our service area. N357Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.Start: 11/18/2005 N358Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice. M55We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.Start: 01/01/1997 M56Missing/incomplete/invalid payer identifier. A copy of this policy is available at www.cms.gov/mcd/search.asp. MA86Missing/incomplete/invalid group or policy number of the insured for the primary coverage. N688Alert: This reversal is due to a medical or utilization review decision. You may bill only one site of service provider number per claim. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.Start: 07/15/2013 N575Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.Start: 07/15/2013 N576Services not related to the specific incident/claim/accident/loss being reported.Start: 07/15/2013 N577Personal Injury Protection (PIP) Coverage.Start: 07/15/2013 N578Coverages do not apply to this loss.Start: 07/15/2013 N579Medical Payments Coverage (MPC).Start: 07/15/2013 N580Determination based on the provisions of the insurance policy.Start: 07/15/2013 N581Investigation of coverage eligibility is pending.Start: 07/15/2013 N582Benefits suspended pending the patient's cooperation.Start: 07/15/2013 N583Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.Start: 07/15/2013 N584Not covered based on the insured's noncompliance with policy or statutory conditions.Start: 07/15/2013 N585Benefits are no longer available based on a final injury settlement.Start: 07/15/2013 N586The injured party does not qualify for benefits.Start: 07/15/2013 N587Policy benefits have been exhausted.Start: 07/15/2013 N588The patient has instructed that medical claims/bills are not to be paid.Start: 07/15/2013 N589Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.Start: 07/15/2013 N590Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.Start: 07/15/2013 N591Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).Start: 07/15/2013 N592Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.Start: 07/15/2013 N593Not covered based on failure to attend a scheduled Independent Medical Exam (IME).Start: 07/15/2013 N594Records reflect the injured party did not complete an Application for Benefits for this loss.Start: 07/15/2013 N595Records reflect the injured party did not complete an Assignment of Benefits for this loss.Start: 07/15/2013 N596Records reflect the injured party did not complete a Medical Authorization for this loss.Start: 07/15/2013 N597Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.Start: 07/15/2013 | Last Modified: 11/01/2013 N598Health care policy coverage is primary.Start: 07/15/2013 N599Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. N418Misrouted claim. MA03If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.Start: 11/01/2008 N510Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. M68Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.Start: 01/01/1997 | Stop: 06/02/2005 M69Paid at the regular rate as you did not submit documentation to justify the modified procedure code. You must request payment from the hospital rather than the patient for this service. N18Payment based on the Medicare allowed amount. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.Start: 11/01/2008 N511Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.Start: 11/01/2008 N512Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.Start: 11/01/2008 N513Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.Start: 11/01/2008 N514Consult plan benefit documents/guidelines for information about restrictions for this service. The appeal request must be filed within 120 days of the date you receive this notice. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. M32Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. N359Missing/incomplete/invalid height.Start: 11/18/2005 N360Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. N479Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).Start: 07/01/2008 N480Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).Start: 07/01/2008 N481Missing Models.Start: 07/01/2008 N482Incomplete/invalid Models. M85Subjected to review of physician evaluation and management services.Start: 01/01/1997 M86Service denied because payment already made for same/similar procedure within set time frame. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. N213Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. N384Records indicate that the referenced body part/tooth has been removed in a previous procedure.Start: 04/01/2007 N385Notification of admission was not timely according to published plan procedures. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. Submit payment information from the primary payer with the secondary claim. Your original claim has been adjusted based on the information received.Start: 03/01/2016 N771Alert: Under Federal law you cannot charge more than the limiting charge amount.Start: 07/01/2016 N772Alert: Rebill urgent/emergent and ancillary services separately.Start: 07/01/2016 N773Drug supplied not obtained from specialty vendor.Start: 07/01/2016 N774Alert: Refer to your Third Party Processor Agreement for specific information on fees associated with this payment type.Start: 07/01/2016 N775Payment adjusted based on x-ray radiograph on film.Start: 11/01/2016 N776This service is not a covered Telehealth service.Start: 11/01/2016 N777Missing Assignment of Benefits Indicator. MA28Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. MA95A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. MA16The patient is covered by the Black Lung Program. N158Transportation in a vehicle other than an ambulance is not covered.Start: 02/28/2003 N159Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.Start: 02/28/2003 N160The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service. M33Missing/incomplete/invalid UPIN for the ordering/referring/performing provider. N105This is a misdirected claim/service for an RRB beneficiary. N475Missing completed referral form.Start: 07/01/2008 N476Incomplete/invalid completed referral form. N39Procedure code is not compatible with tooth number/letter.Start: 01/01/2000 N40Missing radiology film(s)/image(s). M48Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. MA70Missing/incomplete/invalid provider representative signature. N110This facility is not certified for film mammography.Start: 02/28/2002 N111No appeal right except duplicate claim/service issue. N90Covered only when performed by the attending physician.Start: 01/01/2000 N91Services not included in the appeal review.Start: 01/01/2000 N92This facility is not certified for digital mammography.Start: 01/01/2000 N93A separate claim must be submitted for each place of service. M57Missing/incomplete/invalid provider identifier.Start: 01/01/1997 | Stop: 06/02/2005 M58Missing/incomplete/invalid claim information. N133Alert: Services for predetermination and services requesting payment are being processed separately. N197The subscriber must update insurance information directly with payer.Start: 02/25/2003 N198Rendering provider must be affiliated with the pay-to provider.Start: 02/25/2003 N199Additional payment/recoupment approved based on payer-initiated review/audit. Adjudicative decision based on the provisions of a demonstration project.Start: 01/01/2000 N84Alert: Further installment payments are forthcoming. N752Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).Start: 03/01/2015 N753Missing/incomplete/invalid Attachment Control Number.Start: 07/01/2015 N754Missing/incomplete/invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.Start: 07/01/2015 N755Missing/incomplete/invalid ICD Indicator. If the review decision is favorable to you, you do not need to make any refund. N778Missing Primary Care Physician Information.Start: 11/01/2016 N779Replacement/Void claims cannot be submitted until the original claim has finalized. MA63Missing/incomplete/invalid principal diagnosis. You must contact this office immediately upon receipt of an additional payment for this service. They should be comfortable working with computers and the various software required to handle for coding and billing. MA49Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. This payer does not cover items and services furnished to individuals who have been deported.Start: 10/17/2002 N127This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. N41Authorization request denied. You must have a high school diploma and pass an accredited medical coding course. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. People with three or more credentials enjoy an average salary of nearly $67,000 annually. M60Missing Certificate of Medical Necessity. N30Patient ineligible for this service. MA99Missing/incomplete/invalid Medigap information. N19Procedure code incidental to primary procedure.Start: 01/01/2000 N20Service not payable with other service rendered on the same date.Start: 01/01/2000 N21Alert: Your line item has been separated into multiple lines to expedite handling. MA37Missing/incomplete/invalid patient's address. N24Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information. A new capped rental period will not begin. MA113Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. For more information, contact your local

contractor.Start: 11/01/2018 N810Alert: Due to federal, state or local disaster declaration, this claim has been processed at the in-network level of benefit. In addition, a doctor licensed to practice in the United States must provide the service.Start: 02/28/2003 N177Alert: We did not send this claim to patient's other insurer. MA51Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory. N155Alert: Our records do not indicate that other insurance is on file. A claim was not received.Start: 11/01/2012 N561The bundled claim originally submitted for this episode of care includes related readmissions. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. MA19Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. N126Social Security Records indicate that this individual has been deported. N226Incomplete/invalid American Diabetes Association Certificate of Recognition.Start: 08/01/2004 N227Incomplete/invalid Certificate of Medical Necessity.Start: 08/01/2004 N228Incomplete/invalid consent form.Start: 08/01/2004 N229Incomplete/invalid contract indicator.Start: 08/01/2004 N230Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.Start: 08/01/2004 N231Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.Start: 08/01/2004 N232Incomplete/invalid itemized bill/statement. Medicare will reject any claims submitted with the Health Insurance Claim Number (HICN) with a few exceptions. MA121Missing/incomplete/invalid x-ray date. M53Missing/incomplete/invalid days or units of service. N789Clinical Trial is not a covered benefit.Start: 07/01/2017 N790Provider/supplier not accredited for product/service.Start: 07/01/2017 N791Missing history & physical report.Start: 07/01/2017 N792Incomplete/invalid history & physical report.Start: 07/01/2017 N793Alert: Starting January 1, 2020, Medicare will ONLY accept claims submitted with the Medicare Beneficiary Identifier (MBI). MA115Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA). More information can be found at N743Adjusted because the services may be related to an employment accident.Start: 03/01/2015 N744Adjusted because the services may be related to an auto/other accident. Resubmit claim after corrections.Start: 01/01/1997 | Stop: 02/05/2005 M59Missing/incomplete/invalid 'to' date(s) of service. You must offer the patient the choice of changing the rental to a purchase agreement. N831You have not responded to requests to revalidate your provider/supplier enrollment information.Start: 03/01/2020 N832Duplicate occurrence code/occurrence span code.Start: 07/01/2020 N833Patient share of cost waived.Start: 07/01/2020 N834Jurisdiction exempt from sales and health tax charges.Start: 11/01/2020 N835Unrelated Service/procedure/treatment is reduced. N423Claim payment was the result of a payer's retroactive adjustment due to a non standard program.Start: 08/01/2007 N424Patient does not reside in the geographic area required for this type of payment.Start: 08/01/2007 N425Statutorily excluded service(s).Start: 08/01/2007 N426No coverage when self-administered.Start: 08/01/2007 N427Payment for eyeglasses or contact lenses can be made only after cataract surgery.Start: 08/01/2007 N428Not covered when performed in this place of service. MA21SSA records indicate mismatch with name and sex.Start: 01/01/1997 MA22Payment of less than $1.00 suppressed.Start: 01/01/1997 MA23Demand bill approved as result of medical review.Start: 01/01/1997 MA24Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period. MA09Alert: Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement. N794Payment adjusted based on type of technology used.Start: 07/01/2017 N795Item must be resubmitted as a purchase.Start: 11/01/2017 N796Missing/incomplete/invalid Hemoglobin (Hb or Hgb) value.Start: 11/01/2017 N797Missing/incomplete/invalid date qualifier.Start: 11/01/2017 N798Submit a void request for the original claim and resubmit a new claim.Start: 11/01/2017 N799Submitted identifier must be an individual identifier, not group identifier. You must request payment from the SNF rather than the patient for this service.Start: 01/31/2002 N107Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. MA27Missing/incomplete/invalid entitlement number or name shown on the claim. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. Payment amounts are eligible for dispute following the state's documented appeal/ grievance/ arbitration process.Start: 11/01/2021 N859Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. N221Missing Admitting History and Physical report.Start: 08/01/2004 N222Incomplete/invalid Admitting History and Physical report.Start: 08/01/2004 N223Missing documentation of benefit to the patient during initial treatment period.Start: 08/01/2004 N224Incomplete/invalid documentation of benefit to the patient during initial treatment period.Start: 08/01/2004 N225Incomplete/invalid documentation/orders/notes/summary/report/chart. N566Alert: This procedure code requires functional reporting. An allowance was made for a comparable service.Start: 07/15/2013 N632According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due. M44Missing/incomplete/invalid condition code. N4Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.Start: 01/01/1997 MA85Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. M45Missing/incomplete/invalid occurrence code(s). N86A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.Start: 01/01/2000 N87Home use of biofeedback therapy is not covered.Start: 01/01/2000 N88Alert: This payment is being made conditionally. Coinsurance and/or deductible are applicable.Start: 01/01/1997 | Last Modified: 11/01/2014 MA119Provider level adjustment for late claim filing applies to this claim. N351Service date outside of the approved treatment plan service dates.Start: 08/01/2005 N352Alert: There are no scheduled payments for this service. N489Missing referral form.Start: 07/01/2008 N490Incomplete/invalid referral form. M54Missing/incomplete/invalid total charges. N59Alert: Please refer to your provider manual for additional program and provider information. N74Resubmit with multiple claims, each claim covering services provided in only one calendar month.Start: 01/01/2000 N75Missing/incomplete/invalid tooth surface information. MA40Missing/incomplete/invalid admission date. At the conclusion or expiration of the disaster declaration, network payment rules will be reinstated.Start: 11/01/2018 | Last Modified: 03/01/2019 N811Missing Federal Sequestration Reduction from Prior Payer.Start: 11/01/2018 N812The start service date through end service date cannot span greater than 18 months.Start: 11/01/2018 N815Missing/Incomplete/Invalid NDC Unit CountStart: 07/01/2019 N816Missing/Incomplete/Invalid NDC Unit of MeasureStart: 07/01/2019 N817Alert: Applicable laboratories are required to collect and report private payor data and report that data to CMS between January 1, 2020 - March 31, 2020.Start: 07/01/2019 N818Claims Dates of Service do not match Electronic Visit Verification System.Start: 07/01/2019 N819Patient not enrolled in Electronic Visit Verification System.Start: 07/01/2019 N820Electronic Visit Verification System units do not meet requirements of visit.Start: 07/01/2019 N821Electronic Visit Verification System visit not found.Start: 07/01/2019 N822Missing procedure modifier(s).Start: 07/01/2019 | Last Modified: 11/01/2019 N823Incomplete/Invalid procedure modifier(s).Start: 07/01/2019 | Last Modified: 11/01/2019 N824Electronic Visit Verification (EVV) data must be submitted through EVV Vendor.Start: 11/01/2019 N825Early intervention guidelines were not met.Start: 11/01/2019 N826Patient did not meet the inclusion criteria for the Medicare Shared Savings Program.Start: 11/01/2019 N827Missing/Incomplete/Invalid Federal Information Processing Standard (FIPS) Code.Start: 11/01/2019 N828Alert: Payment is suppressed due to a contracted funding.Start: 03/01/2020 N829Missing/incomplete/invalid Diagnostics Exchange Z-Code Identifier.Start: 03/01/2020 N830Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. N555Missing medication list.Start: 07/01/2012 N556Incomplete/invalid medication list.Start: 07/01/2012 N557This claim/service is not payable under our service area. M116Processed under a demonstration project or program. M64Missing/incomplete/invalid other diagnosis. N54Claim information is inconsistent with pre-certified/authorized services.Start: 01/01/2000 N55Procedures for billing with group/referring/performing providers were not followed.Start: 01/01/2000 N56Procedure code billed is not correct/valid for the services billed or the date of service billed. N564Patient did not meet the inclusion criteria for the demonstration project or pilot program.Start: 11/01/2012 N565Alert: This non-payable reporting code requires a modifier. N117This service is paid only once in a patient's lifetime. N22Alert: This procedure code was added/changed because it more accurately describes the services rendered. M144Pre-/post-operative care payment is included in the allowance for the surgery/procedure.Start: 01/01/1997 MA01Alert: If you do not agree with what we approved for these services, you may appeal our decision. We did not forward the claim information. M49Missing/incomplete/invalid value code(s) or amount(s). Rebill only those services rendered outside the inpatient stay.Start: 10/12/2001 MA134Missing/incomplete/invalid provider number of the facility where the patient resides.Start: 10/12/2001 N1Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes. N414This service is allowed 4 times in a 12-month period. MA91Alert: This determination is the result of the appeal you filed. N382Missing/incomplete/invalid patient identifier.Start: 04/01/2007 N383Not covered when deemed cosmetic. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care. M23Missing invoice. M107Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.Start: 01/01/1997 M108Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.Start: 01/01/1997 | Stop: 06/02/2005 M109We have provided you with a bundled payment for a teleconsultation. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.Start: 07/15/2013 N600Adjusted based on the applicable fee schedule for the region in which the service was rendered.Start: 07/15/2013 N601In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.Start: 07/15/2013 N602Adjusted based on the Redbook maximum allowance.Start: 07/15/2013 N603This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.Start: 07/15/2013 N604In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.Start: 07/15/2013 N605This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.Start: 07/15/2013 N606The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). N28Consent form requirements not fulfilled.Start: 01/01/2000 N29Missing documentation/orders/notes/summary/report/chart. N96Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.Start: 08/24/2001 N97Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.Start: 08/24/2001 N98Patient must have had a successful test stimulation in order to support subsequent implantation. MA02Alert: If you do not agree with this determination, you have the right to appeal. Rebill as separate professional and technical components. Submit a claim for each patient visit. N71Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. M131Missing physician financial relationship form. The address may be obtained from the State Insurance Regulatory Authority. N378Missing/incomplete/invalid prescription quantity.Start: 12/01/2006 N379Claim level information does not match line level information.Start: 12/01/2006 N380The original claim has been processed, submit a corrected claim.Start: 04/01/2007 N381Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. The charges will be reconsidered upon receipt of that information.Start: 02/28/2003 N180This item or service does not meet the criteria for the category under which it was billed.Start: 02/28/2003 N181Additional information is required from another provider involved in this service. N32Claim must be submitted by the provider who rendered the service. N531Not qualified for recovery based on direct payment of premium.Start: 03/01/2010 N532Not qualified for recovery based on disability and working status.Start: 03/01/2010 N533Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.Start: 07/01/2010 N534This is an individual policy, the employer does not participate in plan sponsorship.Start: 07/01/2010 N535Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.Start: 07/01/2010 N536We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.Start: 07/01/2010 N537We have examined claims history and no records of the services have been found.Start: 07/01/2010 N538A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.Start: 07/01/2010 N539Alert: We processed appeals/waiver requests on your behalf and that request has been denied.Start: 07/01/2010 N540Payment adjusted based on the interrupted stay policy.Start: 11/01/2010 N541Mismatch between the submitted insurance type code and the information stored in our system.Start: 11/01/2010 N542Missing income verification.Start: 03/08/2011 N543Incomplete/invalid income verification. The medical information we have for this patient does not support the need for this item as billed. N217We pay only one site of service per provider per claim. We cannot process this claim until we have received payment information from the primary and secondary payers.Start: 01/01/1997 MA65Missing/incomplete/invalid admitting diagnosis. N693Alert: This reversal is due to a cancellation of the claim by the provider. N102This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.Start: 10/31/2001 | Stop: 07/01/2016 | Last Modified: 11/01/2013 N103Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. Unless corrected this will not be paid in the future. You may resubmit the original claim to receive a corrected payment based on this readmission.Start: 11/01/2012 N562The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.Start: 11/01/2012 N563Alert: Missing required provider/supplier issuance of advance patient notice of non-coverage. N169This drug/service/supply is covered only when the associated service is covered. MA82Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.Start: 01/01/1997 | Stop: 06/02/2005 MA83Did not indicate whether we are the primary or secondary payer. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. You must file a written request for an appeal within 180 days of the date you receive this notice. Only the technical component is subject to price limitations. N121Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay. M127Missing patient medical record for this service. Refer to the URL provided in the ERA for the payer website to access the appeals process guidelines. N70Consolidated billing and payment applies. N211Alert: You may not appeal this decision. M115This item is denied when provided to this patient by a non-contract or non-demonstration supplier. MA36Missing/incomplete/invalid patient name. MA125Per legislation governing this program, payment constitutes payment in full.Start: 01/01/1997 MA126Pancreas transplant not covered unless kidney transplant performed.Start: 10/12/2001 MA127Reserved for future use.Start: 10/12/2001 | Stop: 06/02/2005 MA128Missing/incomplete/invalid FDA approval number. There’s not much excitement in this job. N628Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.Start: 07/15/2013 N629Reviews/documentation/notes/summaries/reports/charts not requested.Start: 07/15/2013 N630Referral not authorized by attending physician.Start: 07/15/2013 N631Medical Fee Schedule does not list this code. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.Start: 11/01/2012 N567Not covered when considered preventative.Start: 03/01/2013 N568Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.Start: 03/01/2013 N569Not covered when performed for the reported diagnosis.Start: 03/01/2013 N570Missing/incomplete/invalid credentialing data. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.Start: 01/01/1997 MA57Patient submitted written request to revoke his/her election for religious non-medical health care services.Start: 01/01/1997 MA58Missing/incomplete/invalid release of information indicator. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. In the future, we will not pay you for non-plan services. N106Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. MA61Missing/incomplete/invalid social security number. MA71Missing/incomplete/invalid provider representative signature date. N429Not covered when considered routine. N161This drug/service/supply is covered only when the associated service is covered.Start: 02/28/2003 N162Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Adjudicative decision based on law. M19Missing oxygen certification/re-certification. They must have excellent computer skills and the ability to troubleshoot if something amiss occurs with their technology. N190Missing contract indicator. M18Certain services may be approved for home use. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.Start: 01/01/2000 N68Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. This is not a pre-authorization or a guarantee of payment.Start: 11/01/2008 N507Plan distance requirements have not been met.Start: 11/01/2008 N508Alert: This real-time claim adjudication response represents the member responsibility to the provider for services reported. N78The necessary components of the child and teen checkup (EPSDT) were not completed.Start: 01/01/2000 N79Service billed is not compatible with patient location information.Start: 01/01/2000 N80Missing/incomplete/invalid prenatal screening information. Common Reasons for Denial Item billed is same or similar to an item already received in beneficiary's history Next Step How to Avoid Future Denials The Noridian Medicare Portal can be accessed under Same or Similar, option 2, to verify if beneficiary has had same or similar item or call the Noridian Interactive Voice Response (IVR) System for Same or Similar Prior to providing equipment, an Advance Beneficiary Notice of Noncoverage (ABN) may be obtained for items a supplier knows a beneficiary does not qualify for Is there a similar rental item renting and billing in supplier’s system that has not been returned? See the payer's claim submission instructions.Start: 08/01/2007 N419Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.Start: 08/01/2007 N420Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.Start: 08/01/2007 N421Claim payment was the result of a payer's retroactive adjustment due to a review organization decision. M36This is the 11th rental month. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. MA35Missing/incomplete/invalid number of lifetime reserve days. Refer to the upgrade process on the Noridian Medicare website Last Updated Fri, 25 Feb 2022 20:58:02 +0000 M1X-ray not taken within the past 12 months or near enough to the start of treatment.Start: 01/01/1997 M2Not paid separately when the patient is an inpatient.Start: 01/01/1997 M3Equipment is the same or similar to equipment already being used.Start: 01/01/1997 M4Alert: This is the last monthly installment payment for this durable medical equipment. Send any questions regarding supplemental benefits to them. N306Missing/incomplete/invalid acute manifestation date.Start: 12/02/2004 N307Missing/incomplete/invalid adjudication or payment date.Start: 12/02/2004 N308Missing/incomplete/invalid appliance placement date.Start: 12/02/2004 N309Missing/incomplete/invalid assessment date.Start: 12/02/2004 N310Missing/incomplete/invalid assumed or relinquished care date.Start: 12/02/2004 N311Missing/incomplete/invalid authorized to return to work date.Start: 12/02/2004 N312Missing/incomplete/invalid begin therapy date.Start: 12/02/2004 N313Missing/incomplete/invalid certification revision date.Start: 12/02/2004 N314Missing/incomplete/invalid diagnosis date.Start: 12/02/2004 N315Missing/incomplete/invalid disability from date.Start: 12/02/2004 N316Missing/incomplete/invalid disability to date.Start: 12/02/2004 N317Missing/incomplete/invalid discharge hour.Start: 12/02/2004 N318Missing/incomplete/invalid discharge or end of care date.Start: 12/02/2004 N319Missing/incomplete/invalid hearing or vision prescription date.Start: 12/02/2004 N320Missing/incomplete/invalid Home Health Certification Period.Start: 12/02/2004 N321Missing/incomplete/invalid last admission period.Start: 12/02/2004 N322Missing/incomplete/invalid last certification date.Start: 12/02/2004 N323Missing/incomplete/invalid last contact date.Start: 12/02/2004 N324Missing/incomplete/invalid last seen/visit date.Start: 12/02/2004 N325Missing/incomplete/invalid last worked date.Start: 12/02/2004 N326Missing/incomplete/invalid last x-ray date.Start: 12/02/2004 N327Missing/incomplete/invalid other insured birth date.Start: 12/02/2004 N328Missing/incomplete/invalid Oxygen Saturation Test date.Start: 12/02/2004 N329Missing/incomplete/invalid patient birth date.Start: 12/02/2004 N330Missing/incomplete/invalid patient death date.Start: 12/02/2004 N331Missing/incomplete/invalid physician order date.Start: 12/02/2004 N332Missing/incomplete/invalid prior hospital discharge date.Start: 12/02/2004 N333Missing/incomplete/invalid prior placement date.Start: 12/02/2004 N334Missing/incomplete/invalid re-evaluation date. The outlier payment otherwise applicable to this claim has not been paid.Start: 03/01/2010 N524Based on policy this payment constitutes payment in full.Start: 03/01/2010 N525These services are not covered when performed within the global period of another service.Start: 03/01/2010 N526Not qualified for recovery based on employer size.Start: 03/01/2010 N527We processed this claim as the primary payer prior to receiving the recovery demand.Start: 03/01/2010 N528Patient is entitled to benefits for Institutional Services only. Your request for review should include any additional information necessary to support your position. If working at home is a must for you, be sure to discuss this option with potential employers. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. N209Missing/incomplete/invalid taxpayer identification number (TIN). The patient is responsible for payment.Start: 01/01/1997 MA48Missing/incomplete/invalid name or address of responsible party or primary payer. Project or program is ending and additional services may not be paid under this project or program. N432Alert: Adjustment based on a Recovery Audit. Please submit the technical and professional components of this service as separate line items.Start: 01/01/1997 M67Missing/incomplete/invalid other procedure code(s). As result, we cannot pay this claim. M76Missing/incomplete/invalid diagnosis or condition. N15Services for a newborn must be billed separately.Start: 01/01/2000 N16Family/member Out-of-Pocket maximum has been met. Services furnished at multiple sites may not be billed in the same claim.Start: 01/01/2000 N94Claim/Service denied because a more specific taxonomy code is required for adjudication.Start: 01/01/2000 N95This provider type/provider specialty may not bill this service. MA117This claim has been assessed a $1.00 user fee.Start: 01/01/1997 MA118Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. The information was either not reported or was illegible.Start: 01/01/1997 MA05Incorrect admission date patient status or type of bill entry on claim. You have a high level of independence and don’t have to worry about someone constantly looking over your shoulder. M79Missing/incomplete/invalid charge. The claim must be filed to the Payer/Plan in whose service area the equipment was received.Start: 07/01/2012 N559This claim/service is not payable under our service area. However, as you were not previously notified of this, we are paying this time. N694Alert: This reversal is due to a resubmission/change to the claim by the provider.Start: 11/01/2013 N695Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudication.Start: 11/01/2013 N696Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment. N72PPS (Prospective Payment System) code changed by medical reviewers. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home. This amount may be billed to a subsequent payer. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. Adjust amount from AR for that month, ensure that rental was picked up from beneficiary (two suppliers cannot be reimbursed for same month) Was item lost, stolen or irreparably damaged (specific incident)? N203Missing/incomplete/invalid anesthesia time/units. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. MA87Missing/incomplete/invalid insured's name for the primary payer. People who work from home must realize that they will occasionally have to venture out for meetings, training and the like. N411This service is allowed one time in a 6-month period. M35Missing/incomplete/invalid pre-operative photos or visual field results. N633Additional anesthesia time units are not allowed.Start: 07/15/2013 N634The allowance is calculated based on anesthesia time units.Start: 07/15/2013 N635The Allowance is calculated based on the anesthesia base units plus time.Start: 07/15/2013 N636Adjusted because this is reimbursable only once per injury.Start: 07/15/2013 N637Consultations are not allowed once treatment has been rendered by the same provider.Start: 07/15/2013 N638Reimbursement has been made according to the home health fee schedule.Start: 07/15/2013 N639Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.Start: 07/15/2013 N640Exceeds number/frequency approved/allowed within time period.Start: 07/15/2013 N641Reimbursement has been based on the number of body areas rated.Start: 07/15/2013 N642Adjusted when billed as individual tests instead of as a panel.Start: 07/15/2013 N643The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.Start: 07/15/2013 N644Reimbursement has been made according to the bilateral procedure rule.Start: 07/15/2013 N645Mark-up allowance. N202Alert: Additional information/explanation will be sent separately. MA102Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider. You must refund the overpayment to the patient. N388Missing/incomplete/invalid prescription number. M75Multiple automated multichannel tests performed on the same day combined for payment. A new capped rental period will begin with delivery of the equipment. N354Incomplete/invalid invoice. N366Requested information not provided. M31Missing radiology report. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim. N7Alert: Processing of this claim/service has included consideration under Major Medical provisions. You will be notified yearly what the percentages for the blended payment calculation will be.Start: 05/30/2002 N115This decision was based on a Local Coverage Determination (LCD). MA93Non-PIP (Periodic Interim Payment) claim. M8We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.Start: 01/01/1997 M9Alert: This is the tenth rental month. N139Alert: Under 32 CFR 199.13, a non-participating provider is not an appropriate appealing party. N138Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review. Coders with the CPC certification had an average salary of $52,690. It is projected that the field of medical coding will see 20 percent growth in the next decade, per MedicalBillingAndCoding.org.Job Pros and ConsAs with just about any career, medical coding brings about its own list of pros and cons. N214Missing/incomplete/invalid history of the related initial surgical procedure(s). N208Missing/incomplete/invalid DRG code. M81You are required to code to the highest level of specificity. N8Crossover claim denied by previous payer and complete claim data not forwarded. N860Alert: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).Start: 11/01/2021 N861Alert: Mismatch between the submitted Patient Liability/Share of Cost and the amount on record for this recipient.Start: 03/01/2022 N862Alert: Member cost share is in compliance with the No Surprises Act, and is calculated using the lesser of the QPA or billed charge.Start: 03/01/2022 N863Alert: This claim is subject to the No Surprises Act (NSA). MA98Claim Rejected. N386This decision was based on a National Coverage Determination (NCD). N506Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. M135Missing/incomplete/invalid plan of treatment. N11Denial reversed because of medical review.Start: 01/01/2000 N12Policy provides coverage supplemental to Medicare. N147Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.Start: 10/31/2002 N148Missing/incomplete/invalid date of last menstrual period.Start: 10/31/2002 N149Rebill all applicable services on a single claim.Start: 10/31/2002 N150Missing/incomplete/invalid model number.Start: 10/31/2002 N151Telephone contact services will not be paid until the face-to-face contact requirement has been met.Start: 10/31/2002 N152Missing/incomplete/invalid replacement claim information.Start: 10/31/2002 N153Missing/incomplete/invalid room and board rate.Start: 10/31/2002 N154Alert: This payment was delayed for correction of provider's mailing address. Unless corrected, a claim with this ordering provider will not be paid in the future.Start: 07/15/2013 N614Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).Start: 07/15/2013 N615Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. N449Payment based on a comparable drug/service/supply.Start: 07/01/2008 N450Covered only when performed by the primary treating physician or the designee.Start: 07/01/2008 N451Missing Admission Summary Report.Start: 07/01/2008 N452Incomplete/invalid Admission Summary Report.Start: 07/01/2008 N453Missing Consultation Report.Start: 07/01/2008 N454Incomplete/invalid Consultation Report.Start: 07/01/2008 N455Missing Physician Order.Start: 07/01/2008 N456Incomplete/invalid Physician Order.Start: 07/01/2008 N457Missing Diagnostic Report.Start: 07/01/2008 N458Incomplete/invalid Diagnostic Report.Start: 07/01/2008 N459Missing Discharge Summary.Start: 07/01/2008 N460Incomplete/invalid Discharge Summary.Start: 07/01/2008 N461Missing Nursing Notes.Start: 07/01/2008 N462Incomplete/invalid Nursing Notes.Start: 07/01/2008 N463Missing support data for claim.Start: 07/01/2008 N464Incomplete/invalid support data for claim.Start: 07/01/2008 N465Missing Physical Therapy Notes/Report.Start: 07/01/2008 N466Incomplete/invalid Physical Therapy Notes/Report.Start: 07/01/2008 N467Missing Tests and Analysis Report. This service was included in a claim that has been previously billed and adjudicated.Start: 02/28/2002 N112This claim is excluded from your electronic remittance advice.Start: 02/28/2002 N113Only one initial visit is covered per physician, group practice or provider. MA59Alert: The patient overpaid you for these services. N212Charges processed under a Point of Service benefit. Contact insurer for more information.Start: 07/15/2013 N612Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.Start: 07/15/2013 N613Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. For more information regarding these projects, contact your local contractor. N61Rebill services on separate claims.Start: 01/01/2000 N62Dates of service span multiple rate periods. N468Incomplete/invalid Report of Tests and Analysis Report.Start: 07/01/2008 N469Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).Start: 07/01/2008 N470This payment will complete the mandatory medical reimbursement limit.Start: 07/01/2008 N471Missing/incomplete/invalid HIPPS Rate Code.Start: 07/01/2008 N472Payment for this service has been issued to another provider.Start: 07/01/2008 N473Missing certification.Start: 07/01/2008 N474Incomplete/invalid certification. N335Missing/incomplete/invalid referral date.Start: 12/02/2004 N336Missing/incomplete/invalid replacement date.Start: 12/02/2004 N337Missing/incomplete/invalid secondary diagnosis date.Start: 12/02/2004 N338Missing/incomplete/invalid shipped date.Start: 12/02/2004 N339Missing/incomplete/invalid similar illness or symptom date.Start: 12/02/2004 N340Missing/incomplete/invalid subscriber birth date.Start: 12/02/2004 N341Missing/incomplete/invalid surgery date.Start: 12/02/2004 N342Missing/incomplete/invalid test performed date.Start: 12/02/2004 N343Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.Start: 12/02/2004 N344Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.Start: 12/02/2004 N345Date range not valid with units submitted.Start: 03/30/2005 N346Missing/incomplete/invalid oral cavity designation code.Start: 03/30/2005 N347Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.Start: 03/30/2005 N348You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.Start: 08/01/2005 N349The administration method and drug must be reported to adjudicate this service.Start: 08/01/2005 N350Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. N544Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Included in facility payment under a demonstration project. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov. MA04Secondary payment cannot be considered without the identity of or payment information from the primary payer. MA90Missing/incomplete/invalid employment status code for the primary insured. This is the maximum approved under the fee schedule for this item or service. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.Start: 01/01/1997 MA114Missing/incomplete/invalid information on where the services were furnished. The American Academy of Professional Coders offers courses to enable students to receive their certified professional coder (CPC) certification, according to Verywell Health.Average Medical Coder SalaryThe salary of a medical coder varies widely, but it appears that the more accreditations an individual has, the more money he or she will earn, as noted on the medical billing and coding website. MA11Payment is being issued on a conditional basis. N89Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice. N33No record of health check prior to initiation of treatment.Start: 01/01/2000 N34Incorrect claim form/format for this service. M80Not covered when performed during the same session/date as a previously processed service for the patient. N394Incomplete/invalid progress notes/report. N27Missing/incomplete/invalid treatment number. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost sharing.Start: 03/01/2022 N877Alert: This initial payment is provided in accordance with the No Surprises Act. N191The provider must update insurance information directly with payer.Start: 02/28/2003 N192Alert: Patient is a Medicaid/Qualified Medicare Beneficiary.Start: 02/28/2003 | Last Modified: 07/01/2020 N193Alert: Specific federal/state/local program may cover this service through another payer. M24Missing/incomplete/invalid number of doses per vial. If you have collected any amount from the patient for this level of service/any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. Under 45 CFR 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. N233Incomplete/invalid operative note/report. N417This service is allowed 1 time in a 5-year period. If you work at home, you will not have much human interaction during your workday. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days N356Not covered when performed with, or subsequent to, a non-covered service. N109Alert: This claim/service was chosen for complex review. Separate payment is not allowed.Start: 01/01/1997 M16Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate.Start: 03/01/2022 N878Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, but notice and consent was not provided and obtained in a manner consistent with applicable Federal law. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.Start: 01/01/1997 MA17We are the primary payer and have paid at the primary rate. A new capped rental period began with delivery of this equipment.Start: 01/01/1997 M94Information supplied does not support a break in therapy. Please resubmit once payment or denial is received.Start: 11/01/2016 N780Missing/incomplete/invalid end therapy date.Start: 11/01/2016 N781Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. N391Missing emergency department records.Start: 08/01/2007 N392Incomplete/invalid emergency department records.Start: 08/01/2007 N393Missing progress notes/report. We will soon begin to deny payment for this service if billed without a G1-G5 modifier. N167Charges exceed the post-transplant coverage limit.Start: 02/28/2003 N168The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service. The balance of this charge is the patient's responsibility.Start: 11/01/2020 N836Provider W9 or Payee Registration not on file.Start: 11/01/2020 N837Alert: Missing modifier was added.Start: 11/01/2020 N838Alert: Service/procedure postponed due to a federal, state, or local mandate/disaster declaration. M47Missing/incomplete/invalid Payer Claim Control Number. M5Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.Start: 01/01/1997 M6Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. N485Missing Physical Therapy Certification.Start: 07/01/2008 N486Incomplete/invalid Physical Therapy Certification.Start: 07/01/2008 N487Missing Prosthetics or Orthotics Certification.Start: 07/01/2008 N488Incomplete/invalid Prosthetics or Orthotics Certification. N571Alert: Payment will be issued quarterly by another payer/contractor.Start: 03/01/2013 N572This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.Start: 03/01/2013 | Last Modified: 07/01/2014 N573Alert: You have been overpaid and must refund the overpayment. MA25A patient may not elect to change a hospice provider more than once in a benefit period.Start: 01/01/1997 MA26Alert: Our records indicate that you were previously informed of this rule. M14No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.Start: 01/01/1997 M15Separately billed services/tests have been bundled as they are considered components of the same procedure. MA116Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution. In fact, medical coding is one of the top jobs for telecommuting, according to Verywell Health. N77Missing/incomplete/invalid designated provider number. N699Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.Start: 03/01/2014 N700Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.Start: 03/01/2014 N701Payment adjusted based on the Value-based Payment Modifier.Start: 03/01/2014 N702Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.Start: 03/01/2014 N703This service is incompatible with previously adjudicated claims or claims in process.Start: 03/01/2014 N704Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted. MA120Missing/incomplete/invalid CLIA certification number. N135Record fees are the patient's responsibility and limited to the specified co-payment.Start: 10/31/2002 N136Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548. N434Missing/Incomplete/Invalid Present on Admission indicator.Start: 07/01/2008 N435Exceeds number/frequency approved /allowed within time period without support documentation.Start: 07/01/2008 N436The injury claim has not been accepted and a mandatory medical reimbursement has been made.Start: 07/01/2008 N437Alert: If the injury claim is accepted, these charges will be reconsidered.Start: 07/01/2008 N438This jurisdiction only accepts paper claims. N756Missing/incomplete/invalid point of drop-off address.Start: 07/01/2015 N757Adjusted based on the Federal Indian Fees schedule (MLR).Start: 07/01/2015 N758Adjusted based on the prior authorization decision.Start: 07/01/2015 N759Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.Start: 07/01/2015 N760This facility is not authorized to receive payment for the service(s).Start: 11/01/2015 N761This provider is not authorized to receive payment for the service(s).Start: 11/01/2015 N762This facility is not certified for Tomosynthesis (3-D) mammography.Start: 11/01/2015 N763The demonstration code is not appropriate for this claim; resubmit without a demonstration code.Start: 11/01/2015 N764Missing/incomplete/invalid Hematocrit (HCT) value.Start: 03/01/2016 N765This payer does not cover coinsurance assessed by a previous payer. Payment included in the reimbursement issued the facility.Start: 01/01/1997 M98Begin to report the Universal Product Number on claims for items of this type. Most coders have set hours and work a normal 40-hour week with weekends off. N13Payment based on professional/technical component modifier(s).Start: 01/01/2000 N14Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount. N206The supporting documentation does not match the information sent on the claim. N395Missing laboratory report.Start: 08/01/2007 N396Incomplete/invalid laboratory report.Start: 08/01/2007 N397Benefits are not available for incomplete service(s)/undelivered item(s).Start: 08/01/2007 N398Missing elective consent form.Start: 08/01/2007 N399Incomplete/invalid elective consent form.Start: 08/01/2007 N400Alert: Electronically enabled providers should submit claims electronically.Start: 08/01/2007 N401Missing periodontal charting.Start: 08/01/2007 N402Incomplete/invalid periodontal charting.Start: 08/01/2007 N403Missing facility certification.Start: 08/01/2007 N404Incomplete/invalid facility certification.Start: 08/01/2007 N405This service is only covered when the donor's insurer(s) do not provide coverage for the service.Start: 08/01/2007 N406This service is only covered when the recipient's insurer(s) do not provide coverage for the service.Start: 08/01/2007 N407You are not an approved submitter for this transmission format.Start: 08/01/2007 N408This payer does not cover deductibles assessed by a previous payer.Start: 08/01/2007 N409This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.Start: 08/01/2007 N410Not covered unless the prescription changes. N58Missing/incomplete/invalid patient liability amount. M133Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.Start: 01/01/1997 M134Performed by a facility/supplier in which the provider has a financial interest. M123Missing/incomplete/invalid name, strength, or dosage of the drug furnished. This fee is calculated in compliance with Act 6.Start: 07/15/2013 N60980% of the provider's billed amount is being recommended for payment according to Act 6. We will soon begin to deny payment for items of this type if billed without the correct UPN. MA103Hemophilia Add On.Start: 01/01/1997 MA104Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.Start: 03/01/2022 N879Alert: The notice and consent to balance bill, and to be charged out-of-network cost sharing, that was obtained from the patient with regard to the billed services, is not permitted for these services. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. You must send 25 percent of the teleconsultation payment to the referring practitioner.Start: 01/01/1997 M110Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.Start: 01/01/1997 | Stop: 06/02/2005 M111We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.Start: 01/01/1997 M112Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice. However, the medical information we have for this patient does not support the need for this item as billed. N361Payment adjusted based on multiple diagnostic imaging procedure rules N362The number of Days or Units of Service exceeds our acceptable maximum.Start: 11/18/2005 N363Alert: in the near future we are implementing new policies/procedures that would affect this determination. M114This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. N57Missing/incomplete/invalid prescribing date. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. N246State regulated patient payment limitations apply to this service.Start: 12/02/2004 N247Missing/incomplete/invalid assistant surgeon taxonomy.Start: 12/02/2004 N248Missing/incomplete/invalid assistant surgeon name.Start: 12/02/2004 N249Missing/incomplete/invalid assistant surgeon primary identifier.Start: 12/02/2004 N250Missing/incomplete/invalid assistant surgeon secondary identifier.Start: 12/02/2004 N251Missing/incomplete/invalid attending provider taxonomy.Start: 12/02/2004 N252Missing/incomplete/invalid attending provider name.Start: 12/02/2004 N253Missing/incomplete/invalid attending provider primary identifier.Start: 12/02/2004 N254Missing/incomplete/invalid attending provider secondary identifier.Start: 12/02/2004 N255Missing/incomplete/invalid billing provider taxonomy.Start: 12/02/2004 N256Missing/incomplete/invalid billing provider/supplier name.Start: 12/02/2004 N257Missing/incomplete/invalid billing provider/supplier primary identifier.Start: 12/02/2004 N258Missing/incomplete/invalid billing provider/supplier address.Start: 12/02/2004 N259Missing/incomplete/invalid billing provider/supplier secondary identifier.Start: 12/02/2004 N260Missing/incomplete/invalid billing provider/supplier contact information.Start: 12/02/2004 N261Missing/incomplete/invalid operating provider name.Start: 12/02/2004 N262Missing/incomplete/invalid operating provider primary identifier.Start: 12/02/2004 N263Missing/incomplete/invalid operating provider secondary identifier.Start: 12/02/2004 N264Missing/incomplete/invalid ordering provider name.Start: 12/02/2004 N265Missing/incomplete/invalid ordering provider primary identifier.Start: 12/02/2004 N266Missing/incomplete/invalid ordering provider address.Start: 12/02/2004 N267Missing/incomplete/invalid ordering provider secondary identifier.Start: 12/02/2004 N268Missing/incomplete/invalid ordering provider contact information.Start: 12/02/2004 N269Missing/incomplete/invalid other provider name.Start: 12/02/2004 N270Missing/incomplete/invalid other provider primary identifier.Start: 12/02/2004 N271Missing/incomplete/invalid other provider secondary identifier.Start: 12/02/2004 N272Missing/incomplete/invalid other payer attending provider identifier.Start: 12/02/2004 N273Missing/incomplete/invalid other payer operating provider identifier.Start: 12/02/2004 N274Missing/incomplete/invalid other payer other provider identifier.Start: 12/02/2004 N275Missing/incomplete/invalid other payer purchased service provider identifier.Start: 12/02/2004 N276Missing/incomplete/invalid other payer referring provider identifier.Start: 12/02/2004 N277Missing/incomplete/invalid other payer rendering provider identifier.Start: 12/02/2004 N278Missing/incomplete/invalid other payer service facility provider identifier.Start: 12/02/2004 N279Missing/incomplete/invalid pay-to provider name.Start: 12/02/2004 N280Missing/incomplete/invalid pay-to provider primary identifier.Start: 12/02/2004 N281Missing/incomplete/invalid pay-to provider address.Start: 12/02/2004 N282Missing/incomplete/invalid pay-to provider secondary identifier.Start: 12/02/2004 N283Missing/incomplete/invalid purchased service provider identifier.Start: 12/02/2004 N284Missing/incomplete/invalid referring provider taxonomy.Start: 12/02/2004 N285Missing/incomplete/invalid referring provider name.Start: 12/02/2004 N286Missing/incomplete/invalid referring provider primary identifier.Start: 12/02/2004 N287Missing/incomplete/invalid referring provider secondary identifier.Start: 12/02/2004 N288Missing/incomplete/invalid rendering provider taxonomy.Start: 12/02/2004 N289Missing/incomplete/invalid rendering provider name.Start: 12/02/2004 N290Missing/incomplete/invalid rendering provider primary identifier.Start: 12/02/2004 N291Missing/incomplete/invalid rendering provider secondary identifier.Start: 12/02/2004 | Last Modified: 11/01/2010 N292Missing/incomplete/invalid service facility name.Start: 12/02/2004 N293Missing/incomplete/invalid service facility primary identifier.Start: 12/02/2004 N294Missing/incomplete/invalid service facility primary address.Start: 12/02/2004 N295Missing/incomplete/invalid service facility secondary identifier.Start: 12/02/2004 N296Missing/incomplete/invalid supervising provider name.Start: 12/02/2004 N297Missing/incomplete/invalid supervising provider primary identifier.Start: 12/02/2004 N298Missing/incomplete/invalid supervising provider secondary identifier.Start: 12/02/2004 N299Missing/incomplete/invalid occurrence date(s).Start: 12/02/2004 N300Missing/incomplete/invalid occurrence span date(s).Start: 12/02/2004 N301Missing/incomplete/invalid procedure date(s).Start: 12/02/2004 N302Missing/incomplete/invalid other procedure date(s).Start: 12/02/2004 N303Missing/incomplete/invalid principal procedure date.Start: 12/02/2004 N304Missing/incomplete/invalid dispensed date.Start: 12/02/2004 N305Missing/incomplete/invalid injury/accident date. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. No payment issued for this claim with this notice. M39Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.Start: 01/01/1997 M37Not covered when the patient is under age 35. Submit the claim to the payer/plan where the patient resides.Start: 03/01/2015 N748Adjusted because the related hospital charges have not been received.Start: 03/01/2015 N749Missing Blood Gas Report.Start: 03/01/2015 N750Incomplete/invalid Blood Gas Report.Start: 03/01/2015 N751Adjusted because the patient is covered under a Medicare Part D plan. A new capped rental period will not begin.Start: 01/01/1997 M95Services subjected to Home Health Initiative medical review/cost report audit.Start: 01/01/1997 M96The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. An LCD provides a guide to assist in determining whether a particular item or service is covered. N182This claim/service must be billed according to the schedule for this plan.Start: 02/28/2003 N183Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice. MA130Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare. N705Incomplete/invalid documentation.Start: 03/01/2014 N706Missing documentation.Start: 03/01/2014 N707Incomplete/invalid orders.Start: 03/01/2014 N708Missing orders.Start: 03/01/2014 N709Incomplete/invalid notes.Start: 03/01/2014 N710Missing notes.Start: 03/01/2014 N711Incomplete/invalid summary.Start: 03/01/2014 N712Missing summary.Start: 03/01/2014 N713Incomplete/invalid report.Start: 03/01/2014 N714Missing report.Start: 03/01/2014 N715Incomplete/invalid chart.Start: 03/01/2014 N716Missing chart.Start: 03/01/2014 N717Incomplete/Invalid documentation of face-to-face examination.Start: 03/01/2014 N718Missing documentation of face-to-face examination.Start: 03/01/2014 N719Penalty applied based on plan requirements not being met.Start: 03/01/2014 N720Alert: The patient overpaid you. N51Electronic interchange agreement not on file for provider/submitter.Start: 01/01/2000 N52Patient not enrolled in the billing provider's managed care plan on the date of service.Start: 01/01/2000 N53Missing/incomplete/invalid point of pick-up address. N692Alert: This reversal is due to an incorrect rate on the initial adjudication. Professional services were included in the payment made to the facility. N610Alert: Payment based on an appropriate level of care.Start: 07/15/2013 N611Claim in litigation. N697Alert: This reversal is due to a payer's retroactive contract incentive program adjustment. If you have any questions about this notice, please contact this office. N163Medical record does not support code billed per the code definition.Start: 02/28/2003 N164Transportation to/from this destination is not covered. N25This company has been contracted by your benefit plan to provide administrative claims payment services only. N165Transportation in a vehicle other than an ambulance is not covered. N433Resubmit this claim using only your National Provider Identifier (NPI). MA76Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. M99Missing/incomplete/invalid Universal Product Number/Serial Number. N194Technical component not paid if provider does not own the equipment used.Start: 02/25/2003 N195The technical component must be billed separately.Start: 02/25/2003 N196Alert: Patient eligible to apply for other coverage which may be primary. The amount paid is the final out-of-network rate and was calculated based on an All Payer Model Agreement, in accordance with the NSA.Start: 03/01/2022 N864Alert: This claim is subject to the No Surprises Act provisions that apply to emergency services.Start: 03/01/2022 N865Alert: This claim is subject to the No Surprises Act provisions that apply to nonemergency services furnished by nonparticipating providers during a patient visit to a participating facility.Start: 03/01/2022 N866Alert: This claim is subject to the No Surprises Act provisions that apply to services furnished by nonparticipating providers of air ambulance services.Start: 03/01/2022 N867Alert: Cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.Start: 03/01/2022 N868Alert: Cost sharing was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.Start: 03/01/2022 N869Alert: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.Start: 03/01/2022 N870Alert: In accordance with the No Surprises Act, cost sharing was based on the billed amount because the billed amount was lower than the qualifying payment amount.Start: 03/01/2022 N871Alert: This initial payment was calculated based on a specified state law, in accordance with the No Surprises Act.Start: 03/01/2022 N872Alert: This final payment was calculated based on a specified state law, in accordance with the No Surprises Act.Start: 03/01/2022 N873Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.Start: 03/01/2022 N874Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act.Start: 03/01/2022 N875Alert: This final payment equals the amount selected as the out-of-network rate by a Federal Independent Dispute Resolution Entity, in accordance with the No Surprises Act.Start: 03/01/2022 N876Alert: This item or service is covered under the plan. N23Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions. N545Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.Start: 07/01/2011 N546Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.Start: 07/01/2011 N547A refund request (Frequency Type Code 8) was processed previously.Start: 03/06/2012 N548Alert: Patient's calendar year deductible has been met.Start: 03/06/2012 N549Alert: Patient's calendar year out-of-pocket maximum has been met.Start: 03/06/2012 N550Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.Start: 03/01/2022 Please submit a new claim with the complete/correct information.Start: 10/12/2001 MA131Physician already paid for services in conjunction with this demonstration claim. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). N368You must appeal the determination of the previously adjudicated claim.Start: 04/01/2006 N369Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.Start: 04/01/2006 N370Billing exceeds the rental months covered/approved by the payer.Start: 08/01/2006 N371Alert: title of this equipment must be transferred to the patient.Start: 08/01/2006 N372Only reasonable and necessary maintenance/service charges are covered.Start: 08/01/2006 N373It has been determined that another payer paid the services as primary when they were not the primary payer. N766This payer does not cover co-payment assessed by a previous payer.Start: 03/01/2016 N767The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.Start: 03/01/2016 N768Incomplete/invalid initial evaluation report.Start: 03/01/2016 N769A lateral diagnosis is required.Start: 03/01/2016 N770The adjustment request received from the provider has been processed. MA42Missing/incomplete/invalid admission source. If you do not have web access, you may contact the contractor to request a copy of the NCD. MA34Missing/incomplete/invalid number of coinsurance days during the billing period. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.Start: 09/26/2002 N125Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. M87Claim/service(s) subjected to CFO-CAP prepayment review.Start: 01/01/1997 M88We cannot pay for laboratory tests unless billed by the laboratory that did the work. N422Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. M17Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. N691Alert: This reversal is due to a patient submitted appeal. MA67Alert: Correction to a prior claim. Review your records for any wrongfully collected deductible. N389Duplicate prescription number submitted.Start: 08/01/2007 N390This service/report cannot be billed separately. The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.Start: 07/15/2013 N607Service provided for non-compensable condition(s).Start: 07/15/2013 N608The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. No payment issued under fee-for-service Medicare as patient has elected managed care.Start: 01/01/1997 MA74Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned. N130Consult plan benefit documents/guidelines for information about restrictions for this service. M126Missing/incomplete/invalid individual lab codes included in the test. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. M46Missing/incomplete/invalid occurrence span code(s). MA112Missing/incomplete/invalid group practice information. Therefore, we are refunding to the payer that paid as primary on your behalf.Start: 12/01/2006 N374Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.Start: 12/01/2006 N375Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.Start: 12/01/2006 N376Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.Start: 12/01/2006 N377Payment based on a processed replacement claim. N120Payment is subject to home health prospective payment system partial episode payment adjustment. N204Services under review for possible pre-existing condition. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.Start: 01/01/1997 M104Information supplied supports a break in therapy. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. MA84Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. M74This service does not qualify for a HPSA/Physician Scarcity bonus payment. MA96Claim rejected. MA08Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare. MA129This provider was not certified for this procedure on this date of service. MA38Missing/incomplete/invalid birth date.Start: 01/01/1997 | Stop: 06/02/2005 MA39Missing/incomplete/invalid gender. MA60Missing/incomplete/invalid patient relationship to insured. N245Incomplete/invalid plan information for other insurance. N616Alert: This enrollee is in the first month of the advance premium tax credit grace period.Start: 07/15/2013 N617This enrollee is in the second or third month of the advance premium tax credit grace period.Start: 07/15/2013 N618Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.Start: 07/15/2013 N619Coverage terminated for non-payment of premium.Start: 07/15/2013 N620Alert: This procedure code is for quality reporting/informational purposes only.Start: 07/15/2013 N621Charges for Jurisdiction required forms, reports, or chart notes are not payable.Start: 07/15/2013 N622Not covered based on the date of injury/accident.Start: 07/15/2013 N623Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.Start: 07/15/2013 N624The associated Workers' Compensation claim has been withdrawn.Start: 07/15/2013 N625Missing/Incomplete/Invalid Workers' Compensation Claim Number.Start: 07/15/2013 N626New or established patient E/M codes are not payable with chiropractic

care codes.Start: 07/15/2013 N627Service not payable per managed care contract. Patient was transferred/discharged/readmitted during payment episode. Review your records for any wrongfully collected copayment. N186Non-Availability Statement (NAS) required for this service. M51Missing/incomplete/invalid procedure code(s). N176Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. N85Alert: This is the final installment payment. MA68Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN). M137Part B coinsurance under a demonstration project or pilot program. Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. N131Total payments under multiple contracts cannot exceed the allowance for this service.Start: 10/31/2002 N132Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified. MA73Informational remittance associated with a Medicare demonstration. N118This service is not paid if billed more than once every 28 days.Start: 07/30/2002 N119This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days. Send medical records for prior 12 monthsStart: 06/30/2003 N205Information provided was illegible. MA33Missing/incomplete/invalid non-covered days during the billing period. M82Service is not covered when patient is under age 50.Start: 01/01/1997 M83Service is not covered unless the patient is classified as at high risk.Start: 01/01/1997 M84Medical code sets used must be the codes in effect at the time of service. N242Incomplete/invalid radiology film(s)/image(s). MA105Missing/incomplete/invalid provider number for this place of service.Start: 01/01/1997 | Stop: 06/02/2005 MA106PIP (Periodic Interim Payment) claim. M25The information furnished does not substantiate the need for this level of service. M21Missing/incomplete/invalid place of residence for this service/item provided in a home. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.Start: 01/01/1997 MA18Alert: The claim information is also being forwarded to the patient's supplemental insurer. No estimate will be provided for the services that could not be estimated in real-time. MA50Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. N484Incomplete/invalid Periodontal Charts. N170A new/revised/renewed certificate of medical necessity is needed.Start: 02/28/2003 N171Payment for repair or replacement is not covered or has exceeded the purchase price.Start: 02/28/2003 N172The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.Start: 02/28/2003 N173No qualifying hospital stay dates were provided for this episode of care.Start: 02/28/2003 N174This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.Start: 02/28/2003 N175Missing review organization approval. The provider can collect from the Federal/State/ Local Authority as appropriate. N137Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. MA62Alert: This is a telephone review decision. MA79Billed in excess of interim rate.Start: 01/01/1997 MA80Informational notice. MA123Your center was not selected to participate in this study, therefore, we cannot pay for these services.Start: 01/01/1997 MA124Processed for IME only. MA64Our records indicate that we should be the third payer for this claim. M30Missing pathology report. N123Alert: This is a split service and represents a portion of the units from the originally submitted service. MA89Missing/incomplete/invalid patient's relationship to the insured for the primary payer. M113Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program. Also, the work tends to be a bit mundane and routine. N128This amount represents the prior to coverage portion of the allowance.Start: 10/31/2002 N129Not eligible due to the patient's age. N698Alert: This reversal is due to non-payment of the health insurance premiums (Health Insurance Exchange or other) by the end of the premium payment grace period, resulting in loss of coverage. N156Alert: The patient is responsible for the difference between the approved treatment and the elective treatment. Stop rental item, amounts on AR will need to be adjusted Was there a previous supplier within the RUL, and did that supplier continue to bill rental after returned? Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es). In fact, it is one of the fastest growing in the health care industry. N353Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim. MA72Alert: The patient overpaid you for these assigned services. You must have the physician withdraw that claim and refund the payment before we can process your claim.Start: 10/12/2001 MA132Adjustment to the pre-demonstration rate.Start: 10/12/2001 MA133Claim overlaps inpatient stay. N114During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. N689Alert: This reversal is due to a retroactive rate change. Please see www.cms.gov/Medicare/New-Medicare-Card/index.html for more information. N5EOB received from previous payer. We will recover the reimbursement from you as an overpayment. N101Additional information is needed in order to process this claim. Courses can be taken in a traditional brick-and-mortar setting or online. N215Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination. MA32Missing/incomplete/invalid number of covered days during the billing period. M38Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. N134Alert: This represents your scheduled payment for this service. N415This service is allowed 1 time in an 18-month period. N530Not Qualified for Recovery based on enrollment information. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.Start: 07/01/2012 N560The pilot program requires an interim or final claim within 60 days of the Notice of Admission. Resubmit this claim to this payer to provide adequate data for adjudication.Start: 01/01/2000 N9Adjustment represents the estimated amount a previous payer may pay. N239Incomplete/invalid physician financial relationship form.Start: 08/01/2004 N240Incomplete/invalid radiology report.Start: 08/01/2004 N241Incomplete/invalid review organization approval. You must contact the facility for your payment. N783Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. MA100Missing/incomplete/invalid date of current illness or symptoms. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. N439Missing anesthesia physical status report/indicators.Start: 07/01/2008 N440Incomplete/invalid anesthesia physical status report/indicators.Start: 07/01/2008 N441This missed/cancelled appointment is not covered. N207Missing/incomplete/invalid weight. MA41Missing/incomplete/invalid admission type. You will receive a separate notice for the other services reported. Coders are in high demand with an extremely positive growth outlook. MA29Missing/incomplete/invalid provider name, city, state, or zip code.Start: 01/01/1997 | Stop: 06/02/2005 MA30Missing/incomplete/invalid type of bill. M138Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Their behind-the-scenes efforts help to sure that insurance companies are billed for services rendered properly and that hospitals and medical practices receive the correct financial reimbursement.How Does a Person Become a Medical Coder?Medical coders need to have great attention to detail and to work well with numbers. Medical coders are an integral part of the health care system. It is also recommended that people interested in pursuing a career in medical coding take courses in anatomy and medical terminology. MA92Missing plan information for other insurance. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary. No coverage is available.Start: 07/15/2013 N651No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.Start: 07/15/2013 N652The date of service is before the date of loss.Start: 07/15/2013 N653The date of injury does not match the reported date of loss.Start: 07/15/2013 N654Adjusted based on achievement of maximum medical improvement (MMI).Start: 07/15/2013 N655Payment based on provider's geographic region.Start: 07/15/2013 N656An interest payment is being made because benefits are being paid outside the statutory requirement.Start: 07/15/2013 N657This should be billed with the appropriate code for these services.Start: 07/15/2013 N658The billed service(s) are not considered medical expenses.Start: 07/15/2013 N659This item is exempt from sales tax.Start: 07/15/2013 N660Sales tax has been included in the reimbursement.Start: 07/15/2013 N661Documentation does not support that the services rendered were medically necessary.Start: 07/15/2013 N662Alert: Consideration of payment will be made upon receipt of a final bill.Start: 07/15/2013 N663Adjusted based on an agreed amount.Start: 07/15/2013 N664Adjusted based on a legal settlement.Start: 07/15/2013 N665Services by an unlicensed provider are not reimbursable.Start: 07/15/2013 N666Only one evaluation and management code at this service level is covered during the course of care.Start: 07/15/2013 N667Missing prescription. N179Additional information has been requested from the member. M119Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). M65One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. N122Add-on code cannot be billed by itself. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. The claim must be filed to the Payer/Plan in whose service area the Rendering Physician is located.Start: 03/01/2018 N803Submission of the claim for the service rendered is the responsibility of the Contracted Medical Group or Hospital.Start: 03/01/2018 N804Alert: The claim/service was processed through the Outpatient Code Editor (OCE).Start: 07/01/2018 N805Alert: The claim/service was processed through the Correct Code Editor (CCE).Start: 07/01/2018 N806Payment is included in the Global transplant allowance.Start: 07/01/2018 N807Payment adjustment based on the Merit-based Incentive Payment System (MIPS).Start: 07/01/2018 N808Not covered for this provider type / provider specialty.Start: 07/01/2018 N809Alert: The fee schedule amount for this service was adjusted based on prior competitive bidding rates. Many jobs are hybrid between home and office (for example, working four days at home and one in an office environment). M128Missing/incomplete/invalid date of the patient's last physician visit.Start: 01/01/1997 | Stop: 06/02/2005 M129Missing/incomplete/invalid indicator of x-ray availability for review. N63Rebill services on separate claim lines.Start: 01/01/2000 N64The 'from' and 'to' dates must be different.Start: 01/01/2000 N65Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. N157Transportation to/from this destination is not covered. N166Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. MA46Alert: The new information was considered but additional payment will not be issued. The patient has received a separate notice of this denial decision. Please verify your information and submit your secondary claim directly to that insurer. N483Missing Periodontal Charts. N529Patient is entitled to benefits for Professional Services only. M120Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.Start: 01/01/1997 | Stop: 06/02/2005 M121We pay for this service only when performed with a covered cryosurgical ablation.Start: 01/01/1997 M122Missing/incomplete/invalid level of subluxation. MA111Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address. (use N387 instead)Start: 11/01/2008 | Stop: 10/01/2009 N516Records indicate a mismatch between the submitted NPI and EIN.Start: 03/01/2009 N517Resubmit a new claim with the requested information.Start: 03/01/2009 N518No separate payment for accessories when furnished for use with oxygen equipment.Start: 03/01/2009 N519Invalid combination of HCPCS modifiers.Start: 07/01/2009 N520Alert: Payment made from a Consumer Spending Account.Start: 07/01/2009 N521Mismatch between the submitted provider information and the provider information stored in our system.Start: 11/01/2009 N522Duplicate of a claim processed, or to be processed, as a crossover claim.Start: 11/01/2009 | Last Modified: 03/01/2010 N523The limitation on outlier payments defined by this payer for this service period has been met. MA69Missing/incomplete/invalid remarks. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es). M143The provider must update license information with the payer. Actual coverage and member liability amounts will be determined when the claim is processed. N141The patient was not residing in a long-term care facility during all or part of the service dates billed.Start: 10/31/2002 N142The original claim was denied. PHP services must be furnished in accordance with the plan of care.Start: 03/01/2017 N788Alert: The third-party administrator/review organization did not receive the required information. If not already billed, you should bill us for the professional component only.Start: 01/01/1997 M97Not paid to practitioner when provided to patient in this place of service. Contact the insurer if there are any questions. MA43Missing/incomplete/invalid patient status. N669Adjusted based on the Medicare fee schedule.Start: 07/15/2013 N670This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.Start: 07/15/2013 N671Payment based on a jurisdiction cost-charge ratio.Start: 07/15/2013 N672Alert: Amount applied to Health Insurance Offset.Start: 07/15/2013 N673Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.Start: 07/15/2013 N674Not covered unless a pre-requisite procedure/service has been provided.Start: 07/15/2013 N675Additional information is required from the injured party.Start: 07/15/2013 N676Service does not qualify for payment under the Outpatient Facility Fee Schedule.Start: 07/15/2013 N677Alert: Films/Images will not be returned.Start: 11/01/2013 N678Missing post-operative images/visual field results.Start: 11/01/2013 N679Incomplete/Invalid post-operative images/visual field results.Start: 11/01/2013 N680Missing/Incomplete/Invalid date of previous dental extractions.Start: 11/01/2013 N681Missing/Incomplete/Invalid full arch series.Start: 11/01/2013 N682Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.Start: 11/01/2013 N683Missing/Incomplete/Invalid prior treatment documentation.Start: 11/01/2013 N684Payment denied as this is a specialty claim submitted as a general claim.Start: 11/01/2013 N685Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.Start: 11/01/2013 N686Missing/incomplete/Invalid questionnaire needed to complete payment determination.Start: 11/01/2013 N687Alert: This reversal is due to a retroactive disenrollment. M78Missing/incomplete/invalid HCPCS modifier. N116Alert: This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. N477Missing Dental Models.Start: 07/01/2008 N478Incomplete/invalid Dental Models. Services from outside that health plan are not covered. MA47Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. M142Missing American Diabetes Association Certificate of Recognition. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.Start: 01/01/2000 N26Missing itemized bill/statement. N67Professional provider services not paid separately. However, this independence is related to one of the potential cons of the job. Payment based on a higher percentage.Start: 01/01/2000 N17Per admission deductible. M63We do not pay for more than one of these on the same day. If treatment has been discontinued, please contact Customer Service. Your failure to revalidate your enrollment information will result in a payment hold in the near future.Start: 03/06/2012 N551Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.Start: 03/06/2012 N552Payment adjusted to reverse a previous withhold/bonus amount.Start: 03/06/2012 N553Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.Start: 03/06/2012 | Stop: 11/01/2012 N554Missing/Incomplete/Invalid Family Planning Indicator. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. M52Missing/incomplete/invalid 'from' date(s) of service. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.Start: 01/01/1997 M106Information supplied does not support a break in therapy. N140Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. N218You must furnish and service this item for as long as the patient continues to need it. M70Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item. MA107Paper claim contains more than three separate data items in field 19.Start: 01/01/1997 MA108Paper claim contains more than one data item in field 23.Start: 01/01/1997 MA109Claim processed in accordance with ambulatory surgical guidelines.Start: 01/01/1997 MA110Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim. N216We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. N416This service is allowed 1 time in a 3-year period. Call 888-355-9165 for RRB EDI information for electronic claims processing. N81Procedure billed is not compatible with tooth surface code.Start: 01/01/2000 N82Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.Start: 01/01/2000 N83No appeal rights. Please resubmit the claim with the identification number of the provider where this service took place. An HHA episode of care notice has been filed for this patient. The median salary in 2017 was $39,180. This is a notice of denial of payment provided in accordance with the No Surprises Act. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.Start: 01/01/1997 MA97Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number. MA78The patient overpaid you. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.Start: 01/01/1997 MA81Missing/incomplete/invalid provider/supplier signature. You may appeal this determination. N35Program integrity/utilization review decision.Start: 01/01/2000 N36Claim must meet primary payer's processing requirements before we can consider payment.Start: 01/01/2000 N37Missing/incomplete/invalid tooth number/letter. MA15Alert: Your claim has been separated to expedite handling. MA06Missing/incomplete/invalid beginning and/or ending date(s). The patient is not liable for payment for this service. An NCD provides a coverage determination as to whether a particular item or service is covered. MORE FROM QUESTIONSANSWERED.NET Code Description Reason Code: 151 Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. M7No rental payments after the item is purchased, returned or after the total of issued rental payments equals the purchase price. Coverage is limited to demonstration participants.Start: 01/01/1997 M139Denied services exceed the coverage limit for the demonstration.Start: 01/01/1997 M140Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday M141Missing physician certified plan of care. N10Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review. N124Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. M102Service not performed on equipment approved by the FDA for this purpose.Start: 01/01/1997 M103Information supplied supports a break in therapy. M40Claim must be assigned and must be filed by the practitioner's employer.Start: 01/01/1997 M41We do not pay for this as the patient has no legal obligation to pay for this.Start: 01/01/1997 M42The medical necessity form must be personally signed by the attending physician.Start: 01/01/1997 M43Payment for this service previously issued to you or another provider by another carrier/intermediary. M61We cannot pay for this as the approval period for the FDA clinical trial has expired.Start: 01/01/1997 M62Missing/incomplete/invalid treatment authorization code. N784Missing comprehensive procedure code.Start: 11/01/2016 N785Missing current radiology film/images.Start: 11/01/2016 N786Benefit limitation for the orthodontic active and/or retention phase of treatment.Start: 11/01/2016 N787Alert: Under 42 CFR 410.43, an eligible Partial Hospitalization Program (PHP) patient/beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. N188The approved level of care does not match the procedure code submitted.Start: 02/28/2003 N189Alert: This service has been paid as a one-time exception to the plan's benefit restrictions. Not supported by clinical records. N491Missing/Incomplete/Invalid Exclusionary Rider Condition.Start: 07/01/2008 N492Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.Start: 07/01/2008 N493Missing Doctor First Report of Injury.Start: 07/01/2008 N494Incomplete/invalid Doctor First Report of Injury.Start: 07/01/2008 N495Missing Supplemental Medical Report.Start: 07/01/2008 N496Incomplete/invalid Supplemental Medical Report.Start: 07/01/2008 N497Missing Medical Permanent Impairment or Disability Report.Start: 07/01/2008 N498Incomplete/invalid Medical Permanent Impairment or Disability Report.Start: 07/01/2008 N499Missing Medical Legal Report.Start: 07/01/2008 N500Incomplete/invalid Medical Legal Report.Start: 07/01/2008 N501Missing Vocational Report.Start: 07/01/2008 N502Incomplete/invalid Vocational Report.Start: 07/01/2008 N503Missing Work Status Report.Start: 07/01/2008 N504Incomplete/invalid Work Status Report.Start: 07/01/2008 N505Alert: This response includes only services that could be estimated in real-time. N104This claim/service is not payable under our claims jurisdiction area. Improvement is measured through voiding diaries.Start: 08/24/2001 N99Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.Start: 08/24/2001 N100PPS (Prospect Payment System) code corrected during adjudication. Please submit other insurance information for our records. M130Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used. N45Payment based on authorized amount.Start: 01/01/2000 N46Missing/incomplete/invalid admission hour.Start: 01/01/2000 N47Claim conflicts with another inpatient stay.Start: 01/01/2000 N48Claim information does not agree with information received from other insurance carrier.Start: 01/01/2000 N49Court ordered coverage information needs validation.Start: 01/01/2000 N50Missing/incomplete/invalid discharge information. MA44Alert: No appeal rights. It is for reporting/information purposes only. MA101A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. N515Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. Please submit claims to them. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. Enter the PlanID when effective. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. MA88Missing/incomplete/invalid insured's address and/or telephone number for the primary payer. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. N31Missing/incomplete/invalid prescribing provider identifier. N200The professional component must be billed separately.Start: 02/25/2003 N201A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents. N178Missing pre-operative images/visual field results. The refund will be requested separately by another payer/contractor.Start: 03/01/2013 N574Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. N243Incomplete/invalid/not approved screening document.Start: 08/01/2004 N244Incomplete/Invalid pre-operative images/visual field results. N210Alert: You may appeal this decision. M73The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. N73A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. MA14Alert: The patient is a member of an employer-sponsored prepaid health plan. Refund any collected copayment to the member.Start: 11/01/2021 N858Alert: State regulations relating to an Out of Network Medical Emergency Care Act were applied to the processing of this claim. Other factors that can play a role in a coder's salary are location, years of experience and who the employer is.At Home Medical Coding JobsThere are plenty of legitimate work-from-home jobs for medical coders. MA31Missing/incomplete/invalid beginning and ending dates of the period billed. N66Missing/incomplete/invalid documentation. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.Start: 01/01/2000 N69Alert: PPS (Prospective Payment System) code changed by claims processing system. N364Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts. Any amounts applied to deductible or member liability will be applied to the prior plan year from which the procedure was cancelled.Start: 11/01/2020 N839The procedure code was added/changed because the level of service exceeds the compensable condition(s).Start: 03/01/2021 N840Worker's compensation claim filed with a different state.Start: 03/01/2021 N841Alert: North Dakota Administrative Rule 92-01-02-50.3.Start: 03/01/2021 N842Alert: Patient cannot be billed for charges.Start: 03/01/2021 N843Missing/incomplete/invalid Core-Based Statistical Area (CBSA) code.Start: 03/01/2021 N844This claim, or a portion of this claim, was processed in accordance with the Nebraska Legislative LB997 July 24, 2020 - Out of Network Emergency Medical Care Act.Start: 03/01/2021 N845Alert: Nebraska Legislative LB997 July 24, 2020 - Out of Network Emergency Medical Care Act.Start: 03/01/2021 N846National Drug Code (NDC) supplied does not correspond to the HCPCs/CPT billed.Start: 03/01/2021 N847National Drug Code (NDC) billed is obsolete.Start: 03/01/2021 N848National Drug Code (NDC) billed cannot be associated with a product.Start: 03/01/2021 N849Missing Tooth Clause: Tooth missing prior to the member effective date.Start: 03/01/2021 N850Missing/incomplete/invalid narrative explaining/describing this service/treatment.Start: 03/01/2021 N851Payment reduced because services were furnished by a therapy assistant.Start: 07/01/2021 N852The pay-to and rendering provider tax identification numbers (TINs) do not matchStart: 07/01/2021 N853The number of modalities performed per session exceeds our acceptable maximum.Start: 07/01/2021 N854Alert: If you have primary other health insurance (OHI) coverage that has denied services, you must exhaust all appeal levels with your primary OHI before we can consider your claim for reimbursement.Start: 07/01/2021 N855This coverage is subject to the exclusive jurisdiction of ERISA (1974), U.S.C. SEC 1001.Start: 07/01/2021 N856This coverage is not subject to the exclusive jurisdiction of ERISA (1974), U.S.C. SEC 1001.Start: 07/01/2021 N857This claim has been adjusted/reversed. You must contact the inpatient facility for technical component reimbursement. N387Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. M125Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed. MA12You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).Start: 01/01/1997 MA13Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code. N234Incomplete/invalid oxygen certification/re-certification.Start: 08/01/2004 N235Incomplete/invalid pacemaker registration form.Start: 08/01/2004 N236Incomplete/invalid pathology report.Start: 08/01/2004 N237Incomplete/invalid patient medical record for this service.Start: 08/01/2004 N238Incomplete/invalid physician certified plan of care. N668Incomplete/invalid prescription. You must appeal each claim on time. Contact the nearest Military Treatment Facility (MTF) for assistance.Start: 02/28/2003 N187Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.Start: 04/01/2006 N367Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account. MA52Missing/incomplete/invalid date.Start: 01/01/1997 | Stop: 06/02/2005 MA53Missing/incomplete/invalid Competitive Bidding Demonstration Project identification. N412This service is allowed 2 times in a 12-month period. MA66Missing/incomplete/invalid principal procedure code. N430Procedure code is inconsistent with the units billed.Start: 11/05/2007 N431Not covered with this procedure. M100We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.Start: 01/01/1997 M101Begin to report a G1-G5 modifier with this HCPCS. MA54Physician certification or election consent for hospice care not received timely.Start: 01/01/1997 MA55Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.Start: 01/01/1997 MA56Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. Please contact us if the patient is covered by any of these sources. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care. M117Not covered unless submitted via electronic claim. N745Missing Ambulance Report.Start: 03/01/2015 N746Incomplete/invalid Ambulance Report.Start: 03/01/2015 N747This is a misdirected claim/service. N60A valid NDC is required for payment of drug claims effective October 02. M77Missing/incomplete/invalid/inappropriate place of service. N38Missing/incomplete/invalid place of service. M136Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician. M26The information furnished does not substantiate the need for this level of service. M20Missing/incomplete/invalid HCPCS. You must make the request through this office. M22Missing/incomplete/invalid number of miles traveled. M28This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.Start: 01/01/1997 M29Missing operative note/report. They have indicated no additional payment can be made. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. They must be able to drown out the distractions that come from working in their home. MA77Alert: The patient overpaid you. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN.

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