

Type	Reason Code	Remark Code
Inpatient	24 - Charges are covered under a capitation agreement/managed care plan.	N130 - Consult plan benefit documents for information about restrictions for this service.
Inpatient	31 - Patient cannot be identified as our insured.	N365 - This procedure code is not payable. It is for reporting/information purposes only.
Inpatient	31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.
Inpatient	31 - Patient cannot be identified as our insured.	MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
Inpatient	133 - The disposition of this claim/service is pending further review.	N30 - Recipient ineligible for this service.
Inpatient	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.
Inpatient	22 - This care may be covered by another payer per coordination of benefits.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
Inpatient	16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M47 - Missing/incomplete/invalid internal or document control number.
Inpatient	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Inpatient	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Inpatient	7 - The procedure/revenue code is inconsistent with the patient's gender.	M51 - Missing/incomplete/invalid procedure code(s) and/or rates.

Inpatient	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N54 - Claim information is inconsistent with pre-certified/authorized services.
Inpatient	133 - The disposition of this claim/service is pending further review.	N47 - Claim conflicts with another inpatient stay.
Inpatient	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N193 - Specific federal/state/local program may cover this service through another payer.
Inpatient	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N219 - Payment based on previous payer's allowed amount.
Inpatient	31 - Patient cannot be identified as our insured.	M77 - Missing/incomplete/invalid place of service.
Inpatient	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
Inpatient	B22 - This payment is adjusted based on the diagnosis.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Inpatient	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N54 - Claim information is inconsistent with pre-certified/authorized services.
Inpatient	146 - Diagnosis was invalid for the date(s) of service reported.	M76 - Missing/incomplete/invalid diagnosis or condition.
Inpatient	146 - Diagnosis was invalid for the date(s) of service reported.	MA63 - Missing/incomplete/invalid principal diagnosis.
Inpatient	9 - The diagnosis is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.
Inpatient	133 - The disposition of this claim/service is pending further review.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Inpatient	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	M47 - Missing/incomplete/invalid internal or document control number.
Inpatient	133 - The disposition of this claim/service is pending further review.	N29 - Missing documentation/orders/notes/summary/report/chart.
Inpatient	B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	M51 - Missing/incomplete/invalid procedure code(s) and/or rates.
Inpatient	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Inpatient	A8 - Ungroupable DRG.	N208 - Missing/incomplete/invalid DRG code
Inpatient	24 - Charges are covered under a capitation agreement/managed care plan.	M52 - Missing/incomplete/invalid from date(s) of service.
Inpatient	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.
Inpatient	22 - This care may be covered by another payer per coordination of benefits.	N36 - Claim must meet primary payer's processing requirements before we can consider payment.
Inpatient	142 - Monthly Medicaid patient liability amount.	N58 - Missing/incomplete/invalid patient liability amount.
Inpatient	A8 - Ungroupable DRG.	N208 - Missing/incomplete/invalid DRG code
Inpatient	6 - The procedure/revenue code is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.
Inpatient	16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N253 - Missing/incomplete/invalid attending provider primary identifier.
Inpatient	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.

Description
Beneficiary is enrolled in a Medicaid Health Plan.
Beneficiary's assigned benefit plan receives no payment. Eligibility should be verified.
Unable to determine the beneficiary's benefit plan.
Unable to determine the beneficiary's benefit plan due to incomplete or invalid claim information.
Claim indicated a readmission within 15 days of discharge from another inpatient facility.
Missing, incomplete, or invalid admission authorization number.
The beneficiary has other insurance which must be billed prior to Medicaid.
Invalid or missing original TCN.
Invalid or missing original TCN.
Invalid or missing original TCN.
Beneficiary's gender is not valid for the procedure or revenue code billed.

Claim information is inconsistent with the submitted prior authorization number.

The beneficiary was readmitted within 15 days of discharge of another inpatient admission.

Beneficiary is enrolled in a mental health or substance abuse plan.

Medicare coinsurance and deductible amounts are being reviewed.

The service location is incorrect or non-covered based on the beneficiary's benefit plan.

Original TCN has already been adjusted.

The submitted diagnosis code requires manual review.

The dates of service are not within the prior authorization dates of service.

Diagnosis code is not valid based on MDCH coverage.

Diagnosis code is invalid for the date of service.

The beneficiaries age is not valid for the diagnosis code.

Code on claims requires documentation.

Original TCN has already been adjusted.
Code reported on the claim requires manual review.
Missing, incomplete, or invalid surgical procedure code.
Provider not active or enrolled on date of service billed.
Invalid DRG code.
The date of service on this is too old to be processed by CHAMPS and will be reviewed manually.
Information on the claim does not match the service on the prior authorization.
Claims is being reviewed for possible change in other insurance status.
The total patient payment amount reported for claims this month is less than the patients monthly liability amount.
DRG pricing can not be determined because DRG date can not be found on the claim.
Revenue code not valid for beneficiary's age.
Missing, incomplete, or invalid attending provider NPI.
Missing, incomplete, or invalid admission authorization number.