

Type	Reason Code	Remark Code
Nursing Facility	18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.
Nursing Facility	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.
Nursing Facility	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Nursing Facility	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.
Nursing Facility	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Nursing Facility	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.
Nursing Facility	181 - Procedure code was invalid on the date of service.	MA66 - Missing/incomplete/invalid principal procedure code or date.
Nursing Facility	152 - Payer deems the information submitted does not support this length of service.	M54 - Missing/incomplete/invalid total charges.
Nursing Facility	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.
Nursing Facility	31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.
Nursing Facility	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.)	M53 - Missing/incomplete/invalid days or units of service.
Nursing Facility	31 - Patient cannot be identified as our insured.	N365 - This procedure code is not payable. It is for reporting/information purposes only.
Nursing Facility	18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.
Nursing Facility	101 - Predetermination: anticipated payment upon completion of services or claim adjudication.	N185 - Do not resubmit this claim/service.

Nursing Facility	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.)	M50 - Missing/incomplete/invalid revenue code(s).
Nursing Facility	101 - Predetermination: anticipated payment upon completion of services or claim adjudication.	N185 - Do not resubmit this claim/service.
Nursing Facility	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.
Nursing Facility	29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.
Nursing Facility	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Nursing Facility	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.
Nursing Facility	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.)	MA42 - Missing/incomplete/invalid admission source.
Nursing Facility	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.)	MA43 - Missing/incomplete/invalid patient status.
Nursing Facility	151 - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N345 - Date range not valid with units submitted.
Nursing Facility	31 - Patient cannot be identified as our insured.	MA61 - Missing/incomplete/invalid social security number or health insurance claim number.
Nursing Facility	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.

Nursing Facility	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Nursing Facility	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.
Nursing Facility	133 - The disposition of this claim/service is pending further review.	M17 - 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. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
Nursing Facility	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.
Nursing Facility	17 - Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N379 - Claim level information does not match line level information.
Nursing Facility	B5 - Coverage/program guidelines were not met or were exceeded.	N130 - Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
Nursing Facility	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.)	MA40 - Missing/incomplete/invalid admission date.
Nursing Facility	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.)	MA65 - Missing/incomplete/invalid admitting diagnosis.
Nursing Facility	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.

Nursing Facility	29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.
Nursing Facility	B5 - Coverage/program guidelines were not met or were exceeded.	N130 - Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

Description
Claim/Service is a duplicate of a previously paid claim.
Invalid or missing original TCN.
Invalid or missing original TCN.
The dates of service are not within the prior authorization dates of service.
Invalid or missing original TCN.
Claim information is inconsistent with the submitted prior authorization number.
Invalid procedure code on the date of service.
Service accommodation days are missing, incomplete, or invalid.
Original TCN has already been adjusted.
Unable to determine the beneficiary's benefit plan.
Missing, incomplete, or invalid units of service.
Beneficiary's assigned benefit plan receives no payment. Eligibility should be verified.
Claim/Service is a duplicate of a previously paid claim.
Claim adjustment for this TCN is already in process.

Missing, incomplete, or invalid revenue code.

Claim adjustment for this TCN is already in process.

Information on the claim does not match the service on the prior authorization.

The time limit for filing has expired.

The calculated reimbursement amount exceeds the maximum allowed for this provider.

The beneficiary has other insurance which must be billed prior to Medicaid.

Missing, incomplete, or invalid admission source.

Missing, incomplete, or invalid, patient status.

There is an invalid relationship between the claim line date of service and the claim line quantity reported.

Beneficiary ID in missing or invalid.

The beneficiaries age is not valid for the diagnosis code.

The procedure code is inconsistent with the modifier submitted or a required modifier is missing.

Claim is being reviewed for possible Medicare coverage.

Required beneficiary identification information is missing or invalid.

Original TCN has already been adjusted.

The currently number of claim lines does not match the original TCN.

Services billed exceed program limitations.

Missing, incomplete, or invalid admission date.

Missing, incomplete, or invalid, admitting diagnosis code.

Original TCN has already been adjusted.

The time limit for filing has expired.

Services billed exceed program
limitations.