

HEALTHEDGE REASON CODE LEGEND
9/1/2011

Message Code	Short Description
B01	The code {0} has been replaced by the code {1} on service line {2}
B02	The code {0} is part of the more global code {1} on service line {2}
B03	Modifier {4} has been added to this code {0} to denote a secondary procedure
B04	The code {0} has been replaced by a more appropriate code {1} based on the patient's age on service line {2}
B05	The code {0} cannot be accepted more than once within the same claim
B06	The code {0} has been expanded for more appropriate billing on service line(s) {2}
B07	The code {0} has been replaced by a more appropriate code {1} and units {5} on service line {2}
B08	New bundled code {0} added to replace those billed on service line(s) {3}
1	Incorrect Input
2	Manual Adjudication Necessary
3	Change in Member Status
4	Incorrect Provider
5	Incorrect Member
6	Incorrect Service Code
7	Incorrect Allowed Amount
8	Incorrect Provider Returned Monies Paid
9	Service Denied in Error
10	Incorrect Date of Service
11	Incorrect Billed Amount
12	Incorrect Units of Service
13	Incorrect Diagnosis Code
14	Coordination of Benefits Claim
15	Duplicate Claim
16	Member Coverage terminated
17	Incorrect Provider Cashed Check
18	Appeal Claim
19	Authorization Updated
20	Corrected Claim
21	Administrative Decision
22	Eligibility Corrected/Updated
23	System Processing Error
2	Claim was transferred from Repair due to automated reprocessing
2	Claim was transferred from Review due to automated reprocessing
22	Manually readjudicated claim requires review
23	Claim flagged for review due to bundling rules
24	Occurrence code validation failed
28	Overlapping authorizations exist
29	EOB insurer does not match member's other insurer
30	Claim is a candidate for coordination of benefits
31	This claim has no other insurance, no EOB
32	This claim has no EOB
33	Member has other insurance and a service agreement
34	Review claim with attachment and line splitting
35	Claim is for non-contracted out of area provider
36	Potential duplicate service
37	Review triggers found on this claim line
38	Review triggers exist on all lines of this claim
39	COB req review for pay up to billed amt method
4	Inpatient total charges exceed defined threshold
40	Chiro claim for member with WI issue state
401	External fraud detection system processing error. {0}
402	Claim flagged for review due to APC grouper edits.
41	Claim is manually marked as requiring a Review
411	Claim flagged for review by iCES fraud detection system.
42	Claim line member responsibility amount {0} is greater than {1} amount {2}
43	Claim requires manual review because the provider is not contracted
44	Claim requires review payment total greater than {0}
45	Claim requires review member paid amount(s)
5	Outpatient total charges exceed defined threshold
501	Missing teeth information on claim and member record mismatch.

HEALTHEDGE REASON CODE LEGEND
9/1/2011

6	Authorization is required and no match found
1	Suspected Fraud Provider
2	Practice Pattern Analysis
3	Utilization Review
4	Credentialing Incomplete
5	New Provider
6	Matria Stop Process
disabled	Awaiting Disabled Verification
student	Awaiting Student Certification
1	Claim crosses accumulator interval.
100	Manual split required because reinsurer contract {0} changes during service date span. {1}
112	Supplier must provide DRG code for this service.
126	This claim is pended for review because of a suspected pre-existing condition.
169	Potential duplicate claim/service to be reviewed: {0}
2	Historical claim line(s) cross(es) date range:
200	Surgical service line with multiple units
201	More than one authorization matched this service.
202	{0} must be reviewed as it appears the payment should be included in the reimbursement made for the DRG/per diem on this claim.
203	{0} must be reviewed to determine if the services should be paid in addition to the DRG/per diem rate.
204	These charges exceed the stop loss provision therefore {0} must be re-adjudicated to reimburse the stop loss amount.
205	Unable find DME purchase price.
206	Unable process confinement copay for professional or not inpatient claim.
207	Unable to determine surgery order due to manually priced surgical claim(s) {0}.
230	Following lines may have been overpaid due to multiple surgery discount rules: {0}
231	Manual split required because member account {0} effective partially during service date span. {1}
232	Input repricer {0} not defined for member's benefit plan.
233	Multiple default benefit provisions with the same weight found {0}
234	Multiple specific benefit provisions with the same weight found {0}
235	Multiple exclusion override benefit provisions with the same weight found {0}
236	Multiple global utilization management rules with the same weight found {0}
237	Multiple tier utilization management rules with the same weight found {0}
238	Unable to look up the fee for claim line with no service code. Priced according to policy for fee method undetermined
239	Manual split required because DOFR supplier contract {0} changes during service date span. {1}
240	Manual split required because capitated payment component {0} changes during service date span. {1}
3	Manual split required because variable definition component {0} changes during service date span. {1}
4	Manual split required because network definition component {0} changes during service date span. {1}
5	Manual split required because benefit plan component {0} changes during service date span. {1}
60	Manual split required because member {0} changes during service date span. {1}
65	Manual split required because benefit plan {0} changes during service date span. {1}
70	Manual split required because supplier contract {0} changes during service date span. {1}
75	Manual split required because product {0} changes during service date span. {1}
90	Manual split required because supplier {0} changes during service date span. {1}
94	Manual split required because rendering practitioner {0} changes during service date span. {1}
95	Manual split required per day within interval from {0} to {1} for correct evaluation of co-pay amount.
96	Manual split required per day within interval from {0} to {1} since service units can-not be properly allocated within the date range.
97	Manual split required per day within interval from {0} to {1} since service dates overlap Periodic Service Date range.
98	Review required since there is an inpatient claim with admission dates {0} for the line service range {1}.
99	Manual split required because reinsurer {0} changes during service date span. {1}

HEALTHEDGE REASON CODE LEGEND
9/1/2011

412	Claim flagged for repair by iCES fraud detection system.
413	Claim rejected by iCES fraud detection system.
1	Subscriber not found
10	Service begin date out of range
100	Supplier ID missing
1000	Inactive External Diagnosis Code
1001	Inactive patient reason for visit Diagnosis Code
1002	External diagnosis code POA indicator invalid
1003	Other diagnosis code POA indicator invalid
1004	Principal diagnosis code POA indicator invalid
1005	External diagnosis code POA indicator missing
1006	Other diagnosis code POA indicator missing
1007	Principal diagnosis code POA indicator missing
1008	Missing NDC code
1009	Invalid NDC code
1010	Missing NDC code measurement type
1011	Invalid NDC code measurement type
1012	Missing NDC code quantity
1013	Invalid NDC code quantity
1014	Missing NDC code price
1015	Invalid NDC code price
1016	NDC code required for claim line
102	Supplier name missing
103	Supplier state invalid
104	Supplier state missing
105	Supplier zip code invalid
106	Supplier zip code missing
107	Admission Source Code missing
108	Admission Source Code invalid
109	Admission Type Code missing
11	Service Unknown
110	Admission Type Code invalid
111	Admission date missing on inpatient claim
112	Admit Date is invalid
113	Admit Hour missing
114	Admit time invalid
115	Condition Code invalid
116	Condition Code missing
117	Discharge Hour invalid
118	Discharge Hour missing
119	Modifier Code missing
12	Service not age appropriate
120	Occurrence Code Date invalid
121	Occurrence Code invalid
122	From Date is invalid
123	Occurrence span code invalid
124	Through Date invalid
126	Other Diagnosis Code missing
127	Other Procedure Code invalid
128	Principal Diagnosis Code unknown
13	Service not gender appropriate
130	Admit Diagnosis Code unknown
131	Professional diagnosis code missing
132	Principal Procedure Code unknown
133	Principal Procedure Code invalid
134	Principal Procedure Date invalid
136	Revenue Code invalid
137	Revenue Code missing
138	Invalid service date
139	Service Date missing
14	Service not frequency appropriate
140	Service Line Total missing
141	Service Line Total invalid

HEALTHEDGE REASON CODE LEGEND
9/1/2011

142	TOB invalid
143	TOB missing
144	Value Code Amount invalid
145	Value Code invalid
146	Statement covers period from date invalid
147	Statement covers period through date invalid
148	Service to before service from
149	Service Date must be greater or equal to From Date
15	Service not covered by plan
151	Estimated amount incorrect
152	Estimated amount missing
153	Invalid Health Care Company name
154	Health Care Company name missing
155	Lifetime reserve days invalid
156	Notification Date instance invalid
157	Notification Date missing
158	Occurrence Span Code From Date before through Date
159	Patient Status Code invalid
16	Service not valid for supplier class
160	Patient Status Code missing
161	Signature missing
162	Prior Payments greater than Total Charges
164	Non-covered charges missing
165	Statement from date after notification date
166	Statement through date after notification date
168	Subscriber telephone missing
171	Supplier telephone missing
172	Admit Date before statement from date
173	Non Covered Days missing
174	Procedure coding method invalid
175	Procedure coding method missing
176	Release signature indicator missing
177	Covered days missing
178	Coinsurance days missing
179	No service lines
18	Modifier not appropriate
180	ECode Missing
181	ECode Invalid
182	Multiple Payer
183	No Valid Diagnosis
184	Invalid Lab Charge
185	Invalid Anesthesia Time
186	Sec diag code unknown
187	Service Start Date missing
188	Service End Date missing
189	Service Start Date invalid
190	Service End Date invalid
191	Dependent is not an eligible dependent as defined
192	Receipt Date Before Admit
193	Invalid assignment of bnft indicator
194	Missing Attending Practitioner
195	Missing Referring Practitioner
196	Missing Rendering Practitioner
2	Subscription not effective
20	POS not valid for service code
200	Covered days invalid
201	Unable to Work Start Date invalid
202	Unable to Work End Date invalid
203	Hospitalization Start Date invalid
204	Hospitalization End Date invalid
205	Medical signature indicator invalid
206	Statement covers period from date missing
207	Statement covers period through date missing

HEALTHEDGE REASON CODE LEGEND
9/1/2011

208	From Date missing
209	Through Date missing
210	Accept Assignment Indicator missing
211	Accept Assignment Indicator invalid
212	Condition codes not valid for TOB
213	Occurrence codes not valid for TOB
214	Patient Status not valid for TOB
215	Emergency Status Invalid
216	Service Dates within Statement Dates
217	Modifier Required for Service Code
218	Service Code for Practitioner Specialty
219	Practitioner Affiliated with Supplier
22	TOS not valid for service code
220	Amount Paid Greater Than Charges
221	Total Received Amount Invalid
222	Total Charged Amount Invalid
223	Total Balanced Due Amount Invalid
224	Invalid Supplier Reference Number
225	Information Release Ind Invalid
226	Duplicate Claim Number
227	Duplicate claim using custom criteria
228	Invalid Member Match Input
229	Invalid Subscriber Match Input
23	Diagnosis unknown
230	Invalid Supplier Match Input
231	Invalid Supplier Location Match Input
232	Invalid Attending Practitioner
233	Invalid Other Practitioner
234	Invalid Member Location Match Input
235	Invalid Referring Practitioner
237	Not Otherwise Classified Code
239	Invalid Assignment Acceptance
24	Diagnosis not valid for service code
240	Invalid Authorization Number
241	Invalid Home Health Care Prognosis Code
242	Invalid Home Health Care Discharge Facility
243	Invalid Home Health Care Start Service Date
244	Invalid Home Health Care Start Certification Date
245	Invalid Home Health Care End Certification Date
246	Invalid Home Health Care Diagnosis Date
247	Invalid Home Health Care Last Admissions Date
248	Invalid Home Health Care Last Discharge Date
249	Invalid Service Tax
25	Diagnosis not gender appropriate
250	Invalid Facility Tax
251	Invalid Non Covered Day Count
252	Invalid Co Insurance Day Count
253	Invalid Life Time Reserve Day Count
254	Invalid Discharge Hour Count
255	Invalid Attachment
256	Invalid Other Insurance Information
257	Invalid Other Procedure Information
258	Invalid EOB attachment
259	Invalid Non Covered Charges
26	Diagnosis not age appropriate
260	Receipt Date Is After Processing Date
261	Modifier Used More Than Once
262	Diagnosis Used More Than Once
263	Manual Readjudication
264	date of service before member effective start date
265	date of service after member effective end date
266	date of service before supplier effective end date
267	date of service before practitioner effective end date

HEALTHEDGE REASON CODE LEGEND
9/1/2011

268	Practitioner is sanctioned
269	Non-covered service
27	Diagnosis not valid for supplier class
271	Claim amount above user's review threshold
272	Invalid Re-priced tier
273	Invalid Re-priced reason code
274	NonPar out of area provider
276	Statement from date after statement through date
277	Sick newborn dependent is not yet enrolled
278	Well newborn dependent is not yet enrolled
279	Type of carrier is missing
28	Fee cannot be zero
280	Type of carrier is invalid
282	Invalid HCPCS code type
283	Invalid revenue code type
285	Invalid Other Insurance Payer Responsibility Code
286	Invalid Other Insurance Patient Relationship
287	Invalid Other Insurance Subscriber Group Number
288	Invalid Other Insurance Subscriber Group Name
289	Invalid Other Insurance Subscriber Name
29	Service units cannot be zero
290	Invalid Other Insurance Subscriber Id
291	Invalid Other Insurance Subscriber Date Of Birth
292	Invalid Other Insurance Payer Company Name
293	Invalid Other Insurance Adjudication Date
294	Invalid Other Insurance Patient Id
295	Invalid Other Insurance Provider Number
296	Invalid Other Insurance Prior Payment Amounts
297	Invalid Rendered Service Location
298	Missing required service benefit amount(s) on converted supplier invoice claim line
299	Missing HCPCS/revenue code on converted supplier invoice claim line
30	Need assngmnt of bnft indicator
300	Missing billed amount on converted supplier invoice claim line
301	Missing allowed amount on converted supplier invoice claim line
302	Missing unit count on converted supplier invoice claim line
303	Professional diagnosis code invalid
304	Principal diagnosis code missing
305	Principal diagnosis code invalid
306	Admit diagnosis code invalid
307	Other diagnosis code invalid
308	Diagnosis code on claim invalid for age
309	Diagnosis code on claim invalid for gender
31	Need medical record release
310	Diagnosis code on line invalid for gender
311	Diagnosis code on line invalid for age
312	Diagnosis code used more than once
313	Principal Procedure Code missing
314	Principal Procedure Date missing
315	Other Procedure Code missing
316	Other Procedure Date missing
317	Other Procedure Date invalid
318	Inactive Modifier Code
319	Inactive HCPCS Code
32	Unknown practitioner
320	Inactive Revenue Code
321	Inactive Principal Diagnosis Code
322	Inactive Admit Diagnosis Code
323	Inactive Other Diagnosis Code
324	Inactive Professional Diagnosis Code
327	Invalid paid amount for wrap-around plan
328	Invalid member responsibility amount for wrap-around plan
329	Inactive submitted DRG Code
33	Future notification date not allowed

HEALTHEDGE REASON CODE LEGEND
9/1/2011

330	Occurrence span code missing
331	Missing COB attachment company name
332	Missing EOB payment company name
333	Invalid EOB payment company name
334	Invalid Claim Delivery Type
335	Minutes should not be indicated for non-anesthesia service
336	Missing minutes for anesthesia service
337	Invalid member paid to provider amount
34	TOB unknown
35	Revenue code not valid for TOB
40	Amount Paid Format invalid
400	External fraud detection system {0} detected issue: {1}
42	Reference Number Missing
44	POS unknown
45	POS missing
46	Facility zip missing
49	Service line charge invalid
5	Member cannot be identified
50	Service end date before from date
501	Invalid number of radiographs
502	Invalid number of oral images
503	Invalid number of models
504	Invalid tooth system
505	Invalid tooth number or letter
506	Invalid tooth surface
507	Invalid oral cavity
51	TOS unknown
52	TOS missing
54	Date current illness invalid
56	Date similar illness invalid
57	Missing diagnosis pointer
58	Total charges missing
59	Total charges not equal to sum of lines
6	Membership not effective
60	Coverage not in effect
61	Modifier Code unknown
62	Process date prior to notification date
63	Service Code Invalid
64	Service Code Missing
65	Service Date after notification date
66	Service unit count is Invalid
67	Service unit count missing
68	Facility name and address missing
69	Facility zip code missing
7	Supplier could not be identified
70	Member address missing
71	Member address mismatch
72	Member DOB missing
74	Member gender missing
76	Member marital status missing
78	Member relationship to insured missing
80	Member name missing
82	Subscriber Address missing
84	Subscriber DOB missing
86	Subscriber gender missing
88	Subscriber name missing
90	Supplier Address missing
94	Employment status missing
95	Invalid subscriber identification
96	Subscriber identification missing
97	Supplier tax ID invalid
98	Supplier tax ID missing
99	Supplier ID invalid

HEALTHEDGE REASON CODE LEGEND
9/1/2011

990	Missing amount in manual adjudication information
991	Invalid amount in manual adjudication information
992	Missing benefit network in manual adjudication information
993	Invalid benefit network in manual adjudication information
994	Some (but not all) of the claim lines were pre-priced
995	Benefit network in manual adjudication information not matching supplier benefit networks
996	Repricer in manual adjudication information not exist
997	Supplier pay to address changed
998	External diagnosis code invalid
999	Patient reason for visit diagnosis code invalid
338	Invalid Rendering Practitioner
100	This service is delivered by the PCP.
101	This service is delivered by the Covering Practitioner.
102	This service is not delivered by PCP or Covering Practitioner.
10	The services must be split to correctly adjudicate against the supplier's contract
110	Claim matched to at least one authorization with a different date of service than on authorization.
111	Claim matched to at least one authorization with a different service than on authorization.
114	ServiceFrequencyLimit is exceeded.
115	Claim matched to at least one authorization with a different level of care than on authorization.
116	Claim line with multiple units partially matched to authorization dates.
117	Practitioner not affiliated with supplier, paid according to the non-participating provider terms
11	The services were split to correctly adjudicate against the member's benefit plan
120	ManuaClaimDeliveryTypeCodeI split required because base product record changes during service date span.
121	This line or portion of a line is denied because the base product is not effective.
122	This line or portion of a line is denied because the base product status is terminated.
123	This line or portion of a line is denied because the base product status is expired.
124	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
125	Service denied because member has not selected a PCP.
127	These are non-covered services because this is a pre-existing condition
128	Claim dates of service span pre-existing condition boundaries and cannot be unambiguously split.
129	Unknown exception while attempting to assign DRG
12	Member not eligible at the time of service
13	Member was terminated prior to the service date
147	Services rendered by an out of network provider.
148	Benefits adjusted. Plan procedures not followed.
149	Lifetime benefit maximum {0}has been reached
14	Member not eligible on service date
150	Services were split because benefit maximum for lifetime has been reached
151	Fee not found for this service code in fee schedule ({0}). Priced according to policy for fee method undetermined
152	Group run-out period is exceeded
153	Payment adjusted because this procedure/service is not paid separately
154	Previously paid. Payment for this claim/service may have been provided in a previous payment
155	Procedure code was incorrect. This payment reflects the correct code
156	Payment is included in the allowance for another service/procedure
157	This service has been denied by the authorized reviewer. Payment is the responsibility of the member
158	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply
159	These are non-covered services because this is not deemed a `medical necessity' by the payer
15	Non-covered charge(s)
160	Payment denied for absence of authorization or exceeds authorization units
161	Claim was priced by carve-out vendor at the out of network, authorized level
162	Claim was priced by carve-out vendor at the in network, authorized level

HEALTHEDGE REASON CODE LEGEND
9/1/2011

163	Claim was priced by carve-out vendor at the in network, unauthorized level
164	Claim was priced by carve-out vendor at the out of network, unauthorized level
165	Services denied due to an open workers' compensation case
166	Service may be a duplicate submission
167	The allowed amount has been adjusted to pay at the level of care authorized
168	Payment for this service is included in the per diem rate.
16	Service is classified as experimental and therefore not payable
170	Primary payor denied this service
171	This is your TRICARE excess benefit.
172	Payment adjusted because this care may be covered by another payer per coordination of benefits
173	Discount agreed to in Preferred Provider contract
174	Payment reduced for absence of, or exceeded, pre-certification/authorization
175	Statistical paid amount could not be calculated. See server log for errors.
176	Service Line was included in Ambulatory Surgical Center fee.
177	Payment for this service is included in the room and board rate.
179	Payment was adjusted to {0}% due to multiple surgeries performed on the same day.
17	Service is classified as cosmetic and therefore not payable
180	Pricing was adjusted to {0}% due to Modifier Pricing rules.
181	The payment for this service includes reimbursement for charges in excess of the stop loss provision.
182	Reimbursed at per diem rate.
183	Reimbursed at confinement rate.
184	The maximum rental fee has been reimbursed for this service.
185	The Medicare benefit has paid the service in full.
186	Member responsibility amount for this plan was capped at wrapped plan member amount.
187	Allowed amount capped at primary insurers member responsibility.
188	Allowed amount limit {0}has been exceeded by {1}.
189	Allowed amount limit {0}has been reached.
18	Services were split because benefit maximum for this time period has been reached
190	Denied authorization penalty. Member is responsible.
191	Denied authorization penalty. Provider is responsible.
192	No reimbursement penalty. Provider is responsible.
19	Benefit maximum {0} for this time period has been reached
1	Duplicate claim/service
200	This line paid according to the {0} benefit tier.
201	Benefit tier is exceeded within this line.
20	Member is not covered under the subscription identified
210	Denial message overridden by user.
21	Subscription is not valid
220	Lifetime benefit maximum {0} has been exceeded by {1}.
221	Benefit maximum {0} for this time period has been exceeded by {1}.
222	The member account fund balance limit is reached.
223	Grace period for this CDH plan expired.
224	Auto-adjudicate flag on Member Account {0} is off for provider submitted claims.
225	CDH plan is not effective for service.
226	Member is not enrolled in CDH plan.
22	Subscription is in a pended status
23	Subscription was not effective until after the service date
240	This line crosses a pricing tier and was adjusted due to dollars paid in history for this confinement or treatment case.
250	Out-patient service delivered during in-patient confinement.
251	RBRVS calculation factors: {0}
252	Line is split for covered/denied calendar days by service limit: {0}
253	Line is split for member accumulator intervals: {0}
254	Line is split for multiple benefit plan versions: {0}
255	Line is split for multiple member versions: {0}
256	Line is split for multiple product versions: {0}
257	Room and board line is split for paid/unpaid days: {0}
258	Line is split for multiple service authorizations: {0}
259	Line is split for multiple service agreements: {0}
260	Line is split for multiple practitioner versions: {0}
261	Line is split for multiple supplier versions: {0}

HEALTHEDGE REASON CODE LEGEND
9/1/2011

262	Line is split for multiple supplier contracts: {0}
263	Line is split for CDH wrap-around plan year: {0}
264	Line is split for member account effective period: {0}
265	Line is split for multiple benefit plan component versions: {0}
266	Line is split for multiple network definition component versions: {0}
267	Line is split for multiple variable definition component versions: {0}
268	Line is split because service limit is reached
269	Exclusion override applied
300	Line is split because limit on payment against a benefit "{0}" is reached
310	Allowed amount was manually set for this line
311	Benefit network was manually set for this line
312	Member Account is not effective on the claim processing date.
313	Member Account is not effective for the service date range.
314	Line is split for covered/denied reimbursement by service limit: {0}
315	Line is split for covered/denied allowed amount by service limit: {0}
316	Claim line denied due to APC grouper edits.
317	Claim line denied by Ingenix iCES system.
318	Line is split for multiple capitated payment component versions: {0}
24	Subscription was terminated prior to service date
25	Deductible Amount
26	Co-payment Amount
27	Coinsurance Amount
270	Service is excluded from supplier contract
271	DRG code is not present to determine DRG cost.
272	Submitted DRG code was used to determine DRG cost.
273	Line is split because service dates {0} overlap Periodic Service Date range
274	Supplier does not have a contract for member's plan but is in-network
275	Service is denied by repricer.
276	This line is denied per default benefit provision.
277	Service is denied according to fee method or fee method undetermined
28	The member's out of pocket maximum has been met
2	DRG code could not be calculated
32	Supplier contract was not effective until after the service date
33	Supplier contract was terminated prior to the service date
34	Supplier contract is in a pended status
35	The time limit for filing has expired
36	Prompt payment discount applies
37	Late filing penalty applies
38	Interest payment applies
39	Service not included in supplier contract
3	DRG code could not be calculated because there is an invalid principal diagnosis
40	Rental payments made exceed the purchase price
41	Fee cannot be calculated for service code
42	Withhold is applied to the service line
43	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
44	Outlier days are identified and paid
45	Services are included in the DRG payment
46	Services are included in the per diem payment
47	Service payment was reduced because multiple procedures were performed that day to the member
48	Service was denied because the authorization was denied
49	Service has a pended authorization
4	Principal and secondary diagnosis are the same
50	Benefit was reduced because authorization was not received
51	Benefits were denied because no authorization was received
52	Benefits were denied because service exceeds the amount approved through the authorization
53	Service requires review of medical records prior to a payment decision. Please submit medical records for review.
54	The claim indicated the provider is not accepting the assignment, and Health Care Company policy is to process such claims as subscriber-pay claims.

HEALTHEDGE REASON CODE LEGEND
9/1/2011

55	The claim indicated the provider is not accepting the assignment, and Health Care Company policy is to review such claims.
56	The claim indicated the provider is not accepting the assignment, and Health Care Company policy is to deny such claims.
57	ServiceFrequencyLimit validation cannot be unambiguously applied to this service line.
58	This service line is denied because it falls outside the range of days for the occurrence code on the claim.
59	This service line is denied because it exceeds the maximum number of units defined for the range of days for the occurrence code on the claim.
5	DRG code could not be calculated because the surgical Code and principal diagnosis code conflict
61	This line or portion of a line is denied because the date of service is before the {0} coverage is effective.
62	This line or portion of a line is denied because the {0} coverage is terminated.
66	This line or portion of a line is denied because the benefit plan is not effective.
67	This line or portion of a line is denied because the benefit plan is terminated.
68	This line or portion of a line is denied because the benefit plan status is expired.
6	Emergency room visit identified as paid in history same day, to the same hospital as a hospital admission
71	This line or portion of a line is denied because the supplier contract is not effective.
72	This line or portion of a line is denied because the supplier contract status is terminated.
73	This line or portion of a line is denied because the supplier contract status is expired.
76	This line or portion of a line is denied because the benefit plan is not effective.
77	This line or portion of a line is denied because the benefit plan is terminated.
78	This line or portion of a line is denied because the benefit plan is expired.
7	Emergency room visit identified as paid with a member co-payment in history, the same day as a hospital admission
81	This line or portion of a line is denied because the benefit provision is not effective.
82	This line or portion of a line is denied because the benefit provision is terminated.
83	This line or portion of a line is denied because the benefit provision is expired.
84	Unable to determine match to COB, WC, or Subro definition. This line contains multiple records for other insurance info. Some records match LR definition, others don't.
85	Claim eligible for policy or secondary payment evaluation.
86	This claim is a candidate for coordination of benefits, but payment information from the other insurer was not provided.
87	Cannot locate secondary insurance calculation policy.
88	Claim matched to at least one authorization with a different provider than on authorization.
89	Claims of this type are administered by {0}{1}.
8	Pre-admission testing identified as paid in history same day to the same hospital as an inpatient hospital admission
91	This line or portion of a line is denied because the supplier is not effective.
92	This line or portion of a line is denied because the supplier is terminated.
93	This line or portion of a line is denied because the supplier status is expired.
95	This line or portion of a line is denied because the rendering practitioner is not effective.
96	This line or portion of a line is denied because the rendering practitioner status is terminated.
97	This line or portion of a line is denied because the rendering practitioner status is expired.
9	Member service agreement identified as matching services on claim
10	Claim/service adjusted because of the finding of a Review Organization
11	The diagnosis is inconsistent with the procedure
12	Payment adjusted because this care may be covered by another payer per coordination of benefits
13	Not An Eligible Dependent
14	Lifetime Benefit Maximum Exceeded
15	Services Not Provided Or Authorized
16	Discount agreed to in Preferred Provider contract
17	Medically Unnecessary Services
18	Pre-existing Condition
19	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply
1	The procedure code/bill type is inconsistent with the place of service
20	Charges for outpatient services with this proximity to inpatient services are not covered

HEALTHEDGE REASON CODE LEGEND
9/1/2011

21	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
22	Non-covered Charges
23	Payment is included in the allowance for another service/procedure
24	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
25	Patient/Insured health identification number and name do not match
26	Payment adjusted because procedure/service was partially or fully furnished by another provider
27	This provider was not certified/eligible to be paid for this procedure/service on this date of service
28	Send directly to WellCare at P.O. Box 31373 Tampa, FL 33631-3373 attn - Claim Department
2	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
3	=H650
4	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier
499	Message Code Indicates Review
500	Benefits Adjusted
501	Denied As Experimental Or Investigational Services
502	Charges for outpatient services with this proximity to inpatient services are not covered
503	Newborn's services are covered in the mother's Allowance
504	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules
505	Payment has been reduced because multiple surgeries were performed on the same day
506	Payment for this service is included in the room and board/per diem rate
507	Billed prior to authorization
508	Billed past authorization
509	Services not authorized
510	Duplicate previously paid
511	Altered claim/corrective material used
512	Denied due to motor vehicle accident
513	Tax ID discrepancy
514	Subrogation case
515	Not contracted for service
516	No out of network form attached
517	The time limit for filing has expired
518	Maximum number of authorization units previously paid
519	Appeal denied
520	Member not eligible on date of service
521	Appeal upheld
522	Appeal over turned
523	Incorrect provider paid
524	Claim paid provider in error
525	Claim has been adjusted to retract the monies paid to you in error
526	This is reissue of payment from a previously voided/stopped payment
527	Claim has been adjusted to reflect the monies you have returned
528	This claim has benefited per the deductible carry forward provision
529	This claim has benefited per the out of pocket maximum carry forward provision
530	Deductible amount has been taken on this service line
531	Out of Pocket Maximum has been applied on this service line
532	Limit applied to this service line
5	Adjustment amount represents collection against receivable created in prior overpayment
6	Payment is included in the allowance for another service/procedure
7	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate
8	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes
9	Contractual adjustment
24	ADJUSTED - AUTOAUDIT CLAIM PAID AFTER REVIEW
25	ADJUSTED - BASED ON CONTRACTUAL CHANGE
26	ADJUSTED - CHARGES INCLUDED IN GLOBAL PAYMENT
27	ADJUSTED - CLAIM ADJUSTED AT THE APPEAL LEVEL
28	ADJUSTED - CLAIM ADJUSTED TO WAIVE COPAY
29	ADJUSTED - CLAIM RECONSIDERATION - DENIAL STANDS

HEALTHEDGE REASON CODE LEGEND
9/1/2011

30	ADJUSTED - CLAIM PAID TO INCORRECT PROVIDER
31	ADJUSTED - CLAIM PAID UNDER INCORRECT MEMBER ID
32	ADJUSTED - TRANSFERED NEW MEMBER ID ELIGIBILITY
33	ADJUSTED - CODE NOT ALLOWED FOR PROVIDER SPEC
34	ADJUSTED - DENIED SERVICE INCLUDED IN GLOBAL
35	ADJUSTED - DUE TO AUTO AUDIT REVIEW
36	ADJUSTED - DUE TO INTERNAL AUDIT
37	ADJUSTED - DUE TO NHPRI PROCESSING ERROR
38	ADJUSTED - DUE TO RETROACTIVE REVIEW
39	ADJUSTED - RETROTERM OF MBR-BILL PRIME PAYOR
40	ADJUSTED - DUE TO SYSTEM CONSTRAINT
41	ADJUSTED - INCORRECT PMNT- USE FOR CONVERSION ONLY
42	ADJUSTED - REFUND FROM ATTY/OTHER CAR
43	ADJUSTED - LEVEL 1 ADMIN APPEAL DENIAL STANDS
44	ADJUSTED - NOT AN NHPRI MEMBER
45	ADJUSTED - ORIGINALLY DENIED LATE CLAIM
46	ADJUSTED - OTHER CARRIER TERMED BEFORE THIS DOS
47	ADJUSTED - PAID AFTER REVIEW
48	ADJUSTED - AFTER REVIEW PAID
49	ADJUSTED - PAID AT CAPITATED RATE
50	ADJUSTED - PAID AT FEE FOR SERVICE RATE
51	ADJUSTED - PAID DUE TO RETROACTIVE SITE CHANGE
52	ADJUSTED - PAYMENT PER MULTIPLE SURG GUIDELINES
53	ADJUSTED - RETRACTED PROVIDER SVCS/RATE CHANGE
54	ADJUSTED - PAYMENT TO REIMBURSE CHARGES AT 100%
55	ADJUSTED - PER ATTORNEY GENERAL
56	ADJUSTED - PER PROVIDER SERVICES
57	ADJUSTED - PER PROVIDER'S REQUEST
58	ADJUSTED - PREVIOUSLY DENIED CLAIM
59	ADJUSTED - PROVIDER BILLING ERROR
60	ADJUSTED - PROV REQUESTED ADJUSTMENT DUE TO TPL
61	ADJUSTED - PROVIDER RETURNED CHECK
62	ADJUSTED - PROVIDER SUBMITTED CORRECTED BILLED AMT
63	ADJUSTED - RATE INCREASE DUE TO CONTRACTUAL AGRE
64	ADJUSTED - RETRACTED DUE TO COB - BILL PRIMARY
65	ADJUSTED - RETRACTION OF DUPLICATE PAYMENT
66	ADJUSTED - RETROACTIVE AUTHORIZATION
67	ADJUSTED - RETROACTIVE REVIEW - SUBMIT MED RECORDS
68	ADJUSTED - SERVICE SHOULD HAVE BEEN CAPITATED
69	ADJUSTED - SHOULD HAVE PAID FEE FOR SERVICE
70	ADJUSTED - STOPLOSS CLAIM (REIMBURSED BY DHS)
71	ADJUSTED - TIMELY FILING OVERRIDE-APPR BY PROV SVS
72	ADJUSTED - TIMELY FILING REVIEWED, DENIAL STANDS
73	ADJUSTED - TRANSPLANT RELATED, BILL REPRICING COMP
74	ADJUSTED - VIRTUAL EXAMINER HISTORICAL REVIEW
75	ADJUSTED - VIRTUAL EXAMINER REVIEW
76	ADJUSTED - WORKERS COMPENSATION CARRIER IS PRIMARY
77	ADJUSTED - MULTIPLE RADIOLOGY REDUCTION ALLOWANCE
78	Configuration Amend
79	ADJUSTED - NO CHECK ISSUED
THRR1	Institutional Billed Amount Threshold Review
THRR2	Professional Billed Amount Threshold Review
THRR3	Institutional Allowed Amount Threshold Review
THRR4	Professional Allowed Amount Threshold Review
SCATR	Identified Service Category Needs Review
2000	Discharge Status Reason Code Missing
2001	Discharge Status Reason Code Invalid
c1	BCBSRI Claim with missing Supplier