

**UNISYS EDIT CROSS WALK TO HIPAA ADJUSTMENT REASON AND REMITTANCE REMARK CODES**

<b>Edit</b>	<b>Edit Description</b>	<b>HIPAA Adjustment Reason Codes</b>	<b>HIPAA Remittance Remark Codes</b>
1	SNF-No Authorization	B5	
2	SNF-Member Share of Cost Reduced From Contracted Amount	142	
3	Benefit Exhaustion Period Reported	119	
7	Medicare Crossover QMB processing rules applied	A1	N192
10	Medicare Crossover Claim Pays at Zero Dollars	23	
11	HMO Guidelines Apply	24	
12	Medicare covered service must be billed to Medicare	22	
14	TPL Claim Pays At Zero Dollars	23	
15	Service not covered for patients in a Medicaid supported fac	A1	MA101
16	No COB Info on Claim Line	A1	MA04
101	No active provider contract	147	
102	Provider not active for Plan on DOS	147	
103	Invalid approved provider service for provider	B7	
104	Incomplete provider	B7	
105	Provider on Pay hold	133	N35
106	No attending physician ID (outpatient)	125	N253
107	Negative charge on claim line	125	M54
108	Uncredentialed provider	52	N95
109	Claim amt exceeds maximum allowed during mass adjudication	A1	
111	Provider Watch	133	N35
112	Claim amount exceeds the maximum allowed	42	N14
113	Specialty code required for provider	52	N95
114	Provider does not match required type	52	N95
116	Annual Benefit Amount Exceeded	119	
117	Lifetime Benefit Amount Exceeded	35	
119	Family LifeTime Limit exceeded	35	
120	Family Annual Limit exceeded	119	
121	Validate External Provider's Program	A1	
122	PCP reassignment override days	A1	
123	Individual Lifetime Visits Exceeded	119	
124	Family Lifetime Visits Exceeded	119	
125	Partial Units on Lifetime/Individual Visit Limits	119	
126	Partial Units on Lifetime Visit Limits	119	
127	Employer Watch	A1	
128	Remaining visits less than date span. Units not allocated.	125	M53
130	Program Watch	A1	
132	Individual Coinsured Charge Maximum Exceeded	2	
133	Family Coinsured Charge Maximum Exceeded	2	
134	Claim payment amt exceeds max allowed for mass adjudication	42	N14
135	Claim payment amount exceeds the maximum allowed	42	N14
149	Benefit does NOT meet date criteria of the claim	96	N56
150	No contract term found for service	52	N95
151	Excluded Contract Term for Service	52	N95
152	Provider type does not match type required by benefit	52	N95
153	PCP is solely responsible for service: pay as capitated	24	
154	Benefit requires Specialty Code not found on Provider	52	N95
155	Benefit has age restriction	6	N30
156	Provider type does NOT match type required by contract term	52	N95
157	Contract Term requires Specialty Code not found on Provider	8	N95
158	Invalid CPT code on DOS	B18	M51
162	Contract term requires documentation	16	N29
163	Benefit requires documentation	16	N29

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164	Contract requires document review	16	N29
165	Dental Areas on Claim Line and Benefit do not match	96	
166	Benefit procedure NOT found in claims history	107	N161
167	Benefit requires prosthesis designation	16	N29
168	Member does NOT meet age criteria for term	6	N30
169	Claim and contract term modifiers do NOT match	16	M78
170	Claim and contract term type of service do NOT match	16	
171	Term Applies to assigned members only	24	
172	Term does NOT meet date criteria of the claim	96	N56
173	Diagnosis on claim does NOT match terms valid range	47	
174	Procedure code on claim does NOT match terms valid procedure	96	N56
175	Bill type on claim does NOT match contract term	16	MA30
176	Emergency requirements on claim do NOT match contract term	40	N180
177	Term is for EPSDT claims only	52	N180
178	Member is NOT in capitation and contract term is capitated	95	N52
179	Location specific term does NOT match claim	5	
180	No Employer Fee for service	133	
181	Stop Loss Applied to Claim	A2	N14
182	No external price found for provider	147	
183	Submission date exceeds policy termination run-off period	27	
184	DOS end date exceeds policy termination date	27	
185	Location-specific benefit does NOT match claim	5	
186	No skilled nursing coverage	96	N30
187	Benefit requires documents to be reviewed	16	N29
188	Noncontracted provider requires EOMB	16	N4
189	Level of Care Benefit Not Found	96	N188
190	Authorization contract overriding contracted provider	45	N45
192	Benefit requires contracted (PAR) provider	52	N130
194	Restrict Benefit by Date of ONSET	A1	N130
195	Date of Onset is Missing on Claim	16	MA122
196	Benefit requires non-contracted (NONPAR) provider	52	N130
197	Procedure code on claim NOT valid for benefit	96	
198	Date of Service is after paid through date	125	M59
199	Benefit Rider not valid for member/DOS	B5	N30
200	Benefit Day Limit Exceeded	119	
201	No enrollment segment	30	N30
202	No Benefit for Service	96	
203	Benefit is excluded from benefit plan	96	
204	Invalid accommodation days	125	M53
205	Benefit requires authorization	62	M62
206	Benefit Visit Limit Exceeded	119	
207	Benefit Dollar Limit Exceeded	119	
208	Benefit Applies to PCP Only	24	N52
209	Benefit coverage not started	26	
210	Member NOT enrolled on DOS	30	N30
211	Provider is not part of network required for benefit	52	N130
215	Member's share of cost different than entered value	A1	M58
216	No COB entered with a Secondary Enrollment	22	MA04
217	Member has an active restriction on enrollment	30	N30
218	Member lost eligibility during date span	30	N30
219	Provider overlap of global days period	97	N19
221	Assistant surgeon not allowed	54	

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222	Co-Surgeon not allowed	54	
223	Team surgeon not allowed	54	
224	Benefit Requires Manual Review	16	N225
225	Contract Term Requires Manual Review	16	N225
226	Reimburse Member On Non-Par Contract	A1	
230	Multiple surgeries detected	59	
235	Override Reimburse Member option	A1	
236	Benefit requires either authorization or referral document	62	M62
237	COB will be manually distributed on claim lines	A1	
238	Invalid Medicare Action Code	A1	N219
240	Not all standard reserve days have been used	A7	
245	Multiple surgeries - claim submitted missing modifier 51	4	M78
246	Member has Preexisting Condition on DOS for Diagnosis	51	
247	Preexisting Condition May Exist	51	
248	Member policy is Suspended	A1	
252	Pend claim if COB is 0 on secondary enrollment claim	22	MA04
253	Internal enrollment and COB amounts entered	23	N155
254	Medicare non-allowed claim submitted hard copy	22	N4
255	Medicare non-allowed claim submitted electronically	A1	
256	Invalid Medicare COB Amount	22	
257	Visit units have been traded	A1	
258	Emergency Claim does not match Emergency Benefit	A1	
262	Claim requires Pursue and Pay	22	
263	Auto Accident indicated on claim - Pursue and Pay	20	
264	Auto Insurance information on claim - Pursue and Pay	20	
265	Other Insurance indicated on claim - Pursue and Pay	22	
266	Other Insurance information unknown - Pursue and Pay	22	
267	Letter of Inquiry No Response or Outdated - Pursue and Pay	16	MA04
268	COB Coverage Not for Claim Type	22	
269	Benefit requires authorization and has associated penalty	62	M62
271	Benefit Restriction Group Validation Failed	B5	
272	Member does not have coverage code required on benefit	B5	N30
300	Duplicate Claim (member/DOS)	18	
301	Invalid or missing admission date	125	MA40
302	Attending Physician Required for Inpatient Claims	125	N253
303	Claim Total Mismatch	125	M54
304	Invalid Bill Type	16	MA30
305	Primary ICD-9 diagnostic code is required	47	M76
306	Discharge status is required for inpatient and SNF claims	125	N50
307	Duplicate Claim (Same Provider/Member/DOS)	18	M86
308	Invalid Admit Hour (0 -- 23)	125	N46
309	Invalid Discharge Hour (0 -- 23)	125	N317
311	Claim Submission Window Exceeded	29	
312	Invalid coinsurance days for 11x bill type	125	MA34
313	Covered days do not match accommodation revcode days	125	M53
314	Non-covered days less that leave of absence days	125	M53
315	Invalid Lifetime Reserve Days	125	M53
316	Admit type does not match admit source	125	MA42
317	Other agency may be responsible for payment	A1	N193
318	Invalid coinsurance days for 21x bill type	125	MA34
319	Coinsurance days exceeds covered days	125	MA34
320	Coinsurance days missing associated value codes	125	M49

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321	Covered days and coinsured days exceed maximum for hospital	125	MA34
322	Covered days exceeds maximum for hospital	119	MA32
323	Covered days and coinsured days exceed maximum for SNF	119	MA34
324	Covered days exceed maximum for SNF	119	M53
325	Non-covered days exceed statement-covered period	125	M53
326	Life reserve days exceed maximum	35	M53
327	Admit type requires 450 revcode	125	M50
328	Admission Source Required	125	MA42
329	Invalid patient status for bill type	125	MA43
330	Invalid diagnosis code for benefit	11	
332	DRG mismatch with DRGActive product	A8	
333	DRGActive Product Error	A8	
334	APC/OPPS claim pricing failure	147	
335	HIPPS RUGS DOS is not within assessment modifier time period	125	MA31
336	HIPPS RUGS billed amount should not have a dollar amount	125	M54
337	HIPPS RUG rate code requires rehabilitation therapy	16	M50
338	HIPPS RUGS length of stay not in sync with accommodation day	16	M53
339	APC claim has lines that have rolled up into other lines	B15	
340	HH PPS too many SCICs detected. Manual review is required.	133	
341	HH PPS No Rap present for claim	125	
342	HH PPS Therapy threshold not met. Fallback used for payment	125	
343	No matching RAP claim lines	125	
344	No previously processed RAP claim lines	125	
345	Detail line REV code not 0023	16	M50
346	Unable to locate fee schedule	147	
347	RAP has more than one detail line	125	
348	Line #1 date must equal episode start date	125	
349	LUPA episode is not 60 days	16	MA31
350	Valid admit date required for HHPPS	125	MA40
351	Credit for prior RAP payment	23	
352	Previous RAP payment exceeds claim amount	23	
353	Detail line REV code not 0022	16	M50
354	Base fee not found or equals \$0.00	147	
355	SNF provider missing SNF per diem amount	147	
356	Overlapping RAP episodes	18	
357	HHPPS RAP From and Through DOS not equal	16	MA31
358	Micro-Dyn PricerActive component error	A8	
359	Micro-Dyn DRGActive component error	A8	
360	DRG is NOT in the selected DRG Group	A8	
361	No end date on claim configured for Micro-Dyn PricerActive	125	M59
362	For Micro-Dyn PricerActive PlanProvID must be 6 digit number	125	N290
364	Pricing requires provider DRG values-values are not defined	147	N208
365	Pricing requires DRG values-values are not defined	A8	
366	Workers Compensation Claim	19	
367	Contract term requires authorization	62	M62
376	Contract Term Restriction Group Validation Failed	16	
377	EOB not received on Claim	22	MA04
378	No COB Amount on claim	22	MA04
379	Member has privacy payee defined for claim	A1	
380	Other Carrier Paid exceeds Other Carrier Allowed	23	
382	Global payment allocated	97	M15
384	Potential Other Accident	A1	

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400	Gender is invalid for Medical Policy	7	
401	Age is invalid for Medical Policy	6	
402	Maximum units exceeded for Medical Policy	119	
403	Diagnoses invalid for Medical Policy	11	
404	Place of Service invalid for Medical Policy	5	
405	Provider Type is invalid for Medical Policy	52	N95
406	Physician specialty is invalid for Medical Policy	52	N95
407	Modifier(s) is invalid for Medical Policy	16	M78
408	Line failed for Medical Policy Rule	A1	
409	Line failed for Medical Policy rule overridden on Cert	A1	
501	Entry in Local Use field is required	16	
502	Duplicate Line on Same Claim	18	
503	Invalid CPT Modifier	B18	M78
504	Invalid CPT/HCPCS code	B18	M20
505	Invalid Revenue Code	16	M50
506	Modifier Required for CPT/HCPCS	4	M78
507	Revenue Code Requires HCPCS	125	M20
511	Invalid From DOS	125	M52
512	Invalid Thru DOS	125	M59
514	Invalid Revenue Code for Bill Type	16	M50
515	Invalid HCPCS for Revenue Code	125	M20
516	Surgical Procedure Requires HCPCS	125	M20
518	Admit type required for 11x bill type	125	MA41
519	Duplicate Claim Line (Same Member/DOS/CPT(Rev))	18	
521	Procedure code not found or invalid for date of service	125	MA66
522	Duplicate Mem/DOS/Service code/Rendering Phys/Modifier	18	
523	Invalid ICD-9 diagnosis code	47	M76
524	CPT codes billed include bundled and unbundled CPTs	97	M15
525	ICD-9 diagnosis code is not valid on DOS	47	M76
526	Claim submitted out of sequence	16	
530	Insufficient units for date span	16	M53
531	Duplicate Mem/DOS/Service code/Pay To/Modifier	18	
532	Duplicate Mem/DOS/Service code/Pay To/Rendering Phys/Modifie	18	
533	Duplicate Mem/DOS/Pay To/Rendering Phys/Charges	18	
534	Duplicate Modifier Exact Match	18	
536	CPT Code is Bundled wth Other CPT	97	M15
538	Diagnosis Pointer Required on Service Line for ICD-9 Codes	47	
539	Date of Service beyond Pay Thru Date and Grace Period Date	27	N30
540	Date of Service is during the Grace Period	27	N30
542	No Fault Payment Exceeds Allowable	42	
601	Prior Authorization Is Closed	62	M62
602	Prior Authorization Is Awaiting Medical Review	62	
603	Prior Authorization Is Pended	62	
604	Prior Authorization Is Denied	39	M62
606	Prior authorization number NOT found	62	M62
607	Prior authorization not for same member	15	N54
608	Prior authorization not for same provider	15	N54
609	Prior authorization dates do not match claim	15	N54
610	Prior Authorization Services do not match claim	15	N54
611	Prior authorization has no available units	62	
612	Prior authorization has insufficient units remaining	62	N45
613	Claim Requires Manual Processing	133	

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614	No Available Bed Days on Auth	62	
615	Claim Line Exceeds Available Bed Days-Partial Units Paid	62	N45
616	Authorization Line Denied	39	
617	Provider's specialty does not match authorized specialty	52	N95
618	Provider's group does not match authorized group	52	N95
619	Provider's network does not match authorized network	52	N95
620	Provider's participation status does not match authorized	B7	
621	Provider type does not match authorized provider type	52	N95
622	Place of Service does not Match Authorized	15	N54
623	NDC Code Mismatch on Authorization	15	N54
624	Authorization Line Manually Denied	39	N54
625	Authorization Line Manually Pended	62	
628	Claim Line date span crosses calendar/policy year	125	N74
629	Multi unit Claim Line date span crosses calendar/policy year	125	N74
632	No Determining Claims Found	107	
633	A determining claim matched - using that benefit preference	133	
634	Benefit preference selection forced manually through the UI	A2	N161
638	Allow override of contract amt based on benefit preference	42	
641	Multiple Instances of Revenue Code 0024 on Claim	125	
642	Invalid Bill Type found on an IRF claim	125	MA30
643	Multiple or invalid HIPPS codes found on IRF claim	125	
644	Charges were not set to zero on an IRF claim	125	M54
645	Non-covered days reported with code 74 not accurate	125	M53
646	Days must equal payable days + loa days + non-covered days	125	M53
647	Claim line has a revenue code of 018X and a HCPCS/Rate	125	M20
648	Claim line units not = days reflected with span code 74	125	M53
649	Sum of units with accommodation codes not equal covered days	125	M53
650	Charges not equal to daily room rate multiplied by days	125	M54
651	Claim is an interrupted stay	A1	N30
652	Length of stay on claim was less than average length of stay	150	
653	Claim is a short stay	150	
654	Benefits were exhausted during stay	119	N30
655	Benefits were exhausted prior to admission	119	N30
656	Claim is an Interim IRF bill	135	
657	Error encountered with Micro-Dyn IRF Priceractive component	A8	
658	Invalid claim data found on IRF claim	125	
662	Contract for service location on claim was not found	5	M77
700	Invalid Dental Procedure	125	M51
701	Invalid Dental Warranty Period	A1	
702	Invalid CDT code on DOS	125	M51
703	Invalid tooth number	125	N39
704	Invalid tooth surface for tooth	125	N75
705	Submitted code requires billing package	A1	
706	CDT already billed on this date by same provider	18	
707	CDT already billed on this date	18	
708	CDT Requires Tooth	125	N37
709	CDT requires tooth surface	125	N75
710	Service Line has been Downcoded	97	N22
711	Replace obsolete code	A7	N22
750	Inclusively priced ITS claim cannot be priced	A1	
800	Claim Check: Rebundling	97	N20
801	Claim Check: Incidental Services	97	N19

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802	Claim Check: Mutually Exclusive Service	59	N20
803	Claim Check: Assistant Surgeon	54	
804	Claim Check: Age Conflict	6	N30
805	Claim Check: Age Replacement	6	N22
806	Claim Check: Gender Conflict	7	
807	Claim Check: Gender Replacement	7	N22
808	Claim Check: Cosmetic Surgery	50	N30
809	Claim Check: Unlisted Procedure	16	
810	Claim Check: Experimental Procedure	55	
811	Claim Check: Pre-Op Audit	97	M15
812	Claim Check: Post-Op Audit	97	M15
813	Claim Check: Medical Visit	97	N20
814	Claim Check: New Visit E&M Audit	B16	N30
815	Claim Check: Intensity of Service Audit	150	
816	Claim Check: Diag to Procedure Audit	11	M76
817	Claim Check: Cross Provider Total Audit	B20	
818	Claim Check: TPL Audit	20	MA04
819	Claim Check: Claim Stop audit	97	
821	Claim Check: General Error	A1	
822	Claim Check: Exceeded 40 Claim Lines	A1	
824	Claim Check: Future Date of Service Error	110	
825	Claim Check: Add modifier 26 or TC to global billed claim	B20	
913	Manual Pend of Claim	133	
914	Electronic Claim has COB	22	MA04
915	Claim has been manually denied	A1	
916	Claim does not have any service lines	16	
917	Manually-altered pay amount	A7	
918	aQtrans Requires Claim Review	A1	
919	Contract Price on Service Line has been Manually Overridden	A7	
920	Contract Price on Service Line Manually Overridden to Zero	A7	
921	Claim manually priced with no balance checks or validation	A7	
922	Manual Contract Price exceeds Billed Amount on Service Line	125	
930	ITS: Alim Initialization Failed	A1	
931	ITS: Alim L2 Call Failed	A1	
932	ITS: Alim L3 Call Failed	A1	
933	ITS: Alim 90 Call Failed	A1	
934	ITS: Alim C2 Call Failed	A1	
935	ITS: Alim C3 Call Failed	A1	
938	Unable to Adjust ITS Claim	A1	
939	Duplicate SCCF number found during SF import	A1	
940	Status change caused by SF Message Code	A1	
941	Previous claim not found for adjustment	129	
942	Previous claim for adjustment not finalized	A1	
943	Claim reversal for adjustment failed	A1	
944	Multiple enrollments found for member name but no DOB match	30	
945	Multiple enrollments found for member name and DOB	30	
946	Invalid prefix for date of service specified	A1	
947	Local contracted provider found for claim	A1	
948	Multiple local contracted providers found for claim	A1	
949	Must pay provider for assigned ITS Medicare claim	A1	
951	ITS - Initial Global Fee on Claim	A1	
952	ITS - Follow-up Global Fee on Claim	A1	

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953	ITS - Late Follow-up Global Fee on Claim	A1	
954	SF indicates Host plan pays provider for ECRP claim	A1	
955	SF indicates Host plan pays subscriber for ECRP claim	A1	