

MaineCare has updated the *Claim Adjustment Reason Codes* to comply with the current list available at <http://www.wpc-edi.com/codes>

Not all of the codes that are published are used by MaineCare on the Remittance Advice (RA)

ADDS

205	Pharmacy discount card processing fee
200	Expenses incurred during lapse in coverage
	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)
209	
207	NPI denial - Invalid format
206	NPI denial - missing
204	This service/equipment/drug is not covered under the patient's current benefit plan
193	Original payment decision is being maintained. This claim was processed properly the first time.
199	Revenue code and Procedure code do not match.
208	NPI denial - not matched
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service.
	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician
194	
198	Payment adjusted for exceeding precertification/authorization.
202	Payment adjusted due to non-covered personal comfort or convenience services.
	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC Medicare set aside arrangement or other agreement. (Use group code PR).
201	
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
203	Payment adjusted for discontinued or reduced service.
197	Payment adjusted for absence of precertification/authorization.

Discontinued

The following codes are being discontinued as of December 31, 2007.

Not all the codes being discontinued are used by MaineCare. The one most commonly used is 42. This code has been remapped to 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Code 62 will be remapped to 198 - Payment adjusted for exceeding precertification/authorization

120	Patient is covered by a managed care plan.
43	Gramm-Rudman reduction.
D20	Claim/Service missing service/product information.
124	Payer refund amount - not our patient.
	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.
57	
D21	This (these) diagnosis(es) is (are) missing or are invalid
D17	Claim/Service has invalid non-covered days.
D18	Claim/Service has missing diagnosis information.
123	Payer refund due to overpayment.
D19	Claim/Service lacks Physician/Operative or other supporting documentation
71	Primary Payer amount.

- 88 Adjustment amount represents collection against receivable created in prior overpayment.
- 113 Payment denied because service/procedure was provided outside the United States or as a result of war.
- 62 Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- 42 Charges exceed our fee schedule or maximum allowable amount.
- D16 Claim lacks prior payer payment information.

MaineCare is also updating the *Remittance Advice Remark Codes*.

The following codes are being added.

- N425 Statutorily excluded service(s).
- N389 Duplicate prescription number submitted.
- N397 Benefits are not available for incomplete service(s)/undelivered item(s).
- N398 Missing elective consent form.
- N381 Consult our contractual agreement for restrictions/billing/payment information related to these charges.
- N419 Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
- N387 You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.
- N423 Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
- N380 The original claim has been processed, submit a corrected claim.
- N370 Billing exceeds the rental months covered/approved by the payer.
- N424 Patient does not reside in the geographic area required for this type of payment.
- N384 Records indicate that the referenced body part/tooth has been removed in a previous procedure.
- N409 This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
- N416 This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
- N392 Incomplete/invalid emergency department records.
- N376 Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
- N396 Incomplete/invalid laboratory report.
- N394 Incomplete/invalid progress notes or report.
- N427 Payment for eyeglasses or contact lenses can be made only after cataract surgery.
- N429 This is not covered since it is considered routine.
- N371 Alert: title of this equipment must be transferred to the patient.
- N401 Missing periodontal charting.
- N366 Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
- N374 Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
- N417 This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
- N365 This procedure code is not payable. It is for reporting/information purposes only.
- N406 This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
- N410 This is not covered unless the prescription changes.
- N408 This payer does not cover deductibles assessed by a previous payer.
- N422 Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program.
- N407 You are not an approved submitter for this transmission format.
- N382 Missing/incomplete/invalid patient identifier.
- N393 Missing progress notes or report.
- N418 Misrouted claim. See the payer's claim submission instructions.
- N369 Alert: Although this claim has been processed, it is deficient according to state

legislation/regulation.

N405 This service is only covered when the donor's insurer(s) do not provide coverage for the service.

N421 Claim payment was the result of a payer's retrocative adjustment due to a Peer Review Organization decision.

N426 No coverage when self-administered.

N412 This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)

N386 This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.

N390 This service cannot be billed separately.

N367 Alert: The claim information has been forwarded to a Health Savings Account processor for review.

N411 This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)

N415 This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)

N368 You must appeal the determination of the previously adjudicated claim.

N395 Missing laboratory report.

N388 Missing/incomplete/invalid prescription number

N373 It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.

N372 Only reasonable and necessary maintenance/service charges are covered.

N399 Incomplete/invalid elective consent form.

N414 This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)

N420 Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.

N379 Claim level information does not match line level information.

N403 Missing facility certification.

N385 Payment has been adjusted because notification of admission was not timely according to published plan procedures.

N383 Services deemed cosmetic are not covered

N400 Alert: Electronically enabled providers should submit claims electronically.

N391 Missing emergency department records.

N378 Missing/incomplete/invalid prescription quantity.

N404 Incomplete/invalid facility certification.

N428 Service/procedure not covered when performed in this place of service.

N413 This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)

N402 Incomplete/invalid periodontal charting.

N377 Payment adjusted based on a processed replacement claim.

N375 Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.

Discontinued

N361 Charges are adjusted based on multiple diagnostic imaging procedure rules.

N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.