ERA Adjustment Codes Reclassified as Denied in Version 14.9

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Version 14.19

Overview

The following table depicts the reclassification of ERA Adjustment Codes to Denied in the OP 14.9 release. Clients running a version of the OP software prior to version 14.9 will not see this mapping in their system. If it is determined that you would like to edit the ERA Match Status for any of the following HL7 ID codes, visit **Default Adjudication Match Status** to learn how to make those edits.

HL7 ID Code	Description
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient age.
7	The procedure/revenue code is inconsistent with the patient gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient age.
10	The diagnosis is inconsistent with the patient gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
	Claim/service lacks information which is needed for adjudication. Additional information

16	is supplied using remittance advice remarks codes whenever appropriate
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments
29	The time limit for filing has expired.
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
50	These are non-covered services because this is not deemed a medical necessity by the payer.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed proven to be effective by the payer.
57	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 days supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
119	Benefit maximum for this time period or occurrence has been reached.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support this length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.

154	Payment adjusted because the payer deems the information submitted does not support this days supply.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty
178	Payment adjusted because the patient has not met the required spend down requirements.
179	Payment adjusted because the patient has not met the required waiting requirements
180	Payment adjusted because the patient has not met the required residency requirements
181	Payment adjusted because this procedure code was invalid on the date of service
182	Payment adjusted because the procedure modifier was invalid on the date of service
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
189	Not otherwise classified or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
197	Payment adjusted for absence of precertification/authorization/notification.
199	Revenue code and Procedure code do not match.
204	This service/equipment/drug is not covered under the patient’s current benefit plan.
206	NPI denial - missing.
207	NPI denial - Invalid format.
208	NPI denial - not matched.

210	Payment adjusted because pre-certification/authorization not received in a timely fashion.
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
A1	Claim denied charges.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
226	Information requested from provider not provided or insufficient/incomplete
236	Procedure or procedure/modifier combination not compatible with another procedure or procedure/modifier combination provided on the same day according to NUCC guidelines
242	Services not provided by network/primary care providers
250	Received attachment/other documentation was incorrect. Expected attachment/document is still missing.
251	Received attachment/other documentation was incomplete or deficient. Necessary information is still needed to process the claim.
252	An attachment/other documentation is required to adjudicate this claim/service
P9	No available or correlating CPT/HCPCS code to describe this service
P14	Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day
282	Procedure/revenue code is inconsistent with the type of bill

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