

Claims Adjudication Reason List with AlphaMCS and HIPAA Reason Codes



MCS Reason ID	HIPAA Reason ID	Service Description
1	45	Adjusted - Above contract rate
2	92	Approved
3	198	Authorized units Exceeded
4	119	Max Basic Units Exhausted
5	29	Claim received after billing period
6	110	Claim submitted before service date
7	22	Client has other covered insurance (COB)
8	204	Client not covered by contract
9	185	Clinician not licensed to provide the service or license has expired
10	2	Coinsurance Amount
11	59	Another concurrent service has been approved or waiting to be processed
13	198	Daily limit exceeded
14	204	Discontinued Service
15	18	Duplicate Claim
16	11	DX code is invalid for service/insurance combination
18	31	Patient not enrolled on the date of service
19	140	Incorrect Member – Patient not enrolled on DOS
20	181	Invalid Service or Service Discontinued
21	6	Invalid age group and procedure code combination
23	9	Invalid Diagnosis/Age Combination
24	11	Invalid PC/DX Combo
25	5	Missing/incomplete/invalid place of service
26	208	Missing/incomplete/invalid provider identifier
27	206	Invalid provider NPI number
28	206	Invalid rendering/attending provider NPI number
30	119	Monthly case rate already paid
31	198	Monthly limit exceeded
32	147	No rates available
33	46	Non-billable Service
35	197	Service is not authorized
36	181	Service not in contract
37	181	Service not in provider profile
38	24	Sub-capitated Provider/Service
39	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
40	198	Weekly limit exceeded
41	123	Readju – Audit Payback
42	123	Readju – Audit Payback
43	125	Readju – Audit Recoup
44	62	Readju – Authorization/Treatment Revisions
45	125	Readju – Billing Days Extended
46	125	Readju – Billing Terms Revised
47	125	Readju – Client Manually Matched
48	125	Readju – Contract Terminated
50	18	Readju – Duplicate Claims
51	22	Readju – EOB Required
52	125	Readju – Other
53	22	Readju – Other Primary Insurance
54	2	Readju – Patient Liability
55	125	Readju – Provider Billing Error
56	125	Readju – Provider ID Incorrect
57	125	Readju – Rate Change
58	123	Overid – Audit Payback

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59	123	Overid – Audit Payback
60	125	Overid – Audit Recoup
61	62	Overid – Authorization/Treatment Revisions
62	125	Overid – Billing Terms Revised
63	125	Overid – Contract Terminated
65	18	Overid – Duplicate Claims
66	22	Overid – EOB Required
67	62	Overid – Missing/incomplete/invalid treatment authorization code
68	125	Overid – Other
69	22	Overid – Other Primary Insurance
70	142	Overid –Patient Liability
71	125	Overid – Provider Billing Error
72	125	Overid – Rate Change
73	123	Revert – Audit Payback
74	123	Revert – Audit Payback
75	125	Revert – Audit Recoup
76	62	Revert – Authorization/Treatment Revisions
77	125	Revert – Billing Terms Revised
78	125	Revert – Contract Terminated
80	18	Revert – Duplicate Claims
81	22	Revert – EOB Required
82	125	Revert – Other
83	22	Revert – Other Primary Insurance
84	2	Revert – Patient Liability
85	125	Revert – Provider Billing Error
87	142	Adjusted Against Co-Insurance
88	11	Invalid Inpatient/ED DX Code
89	147	No contract exists or rate is not set up yet
90	48	Non-Covered Ancillary Services
91	199	Invalid Revenue Code
92	23	Excess amount over allowed Medicare copayment
97	119	Charges are covered under a capitation agreement/managed care plan
104	125	Loaded from legacy system – No reason available
105	125	Pended for manual review
106	125	Pended for COB since patient has no COB on record
107	5	The procedure code/bill type is inconsistent with the place of service
108	31	No coverage available for Patient/Service/Provider combo
109	197	Service is not authorized for the supplied site
110	22	Revert – Retroactive Medicaid
111	22	Revert – Medicaid coverage
112	234	Add-on code cannot be billed by itself
113	8	The taxonomy code for the billing provider is missing
114	8	Missing/Incomplete/Invalid attending/rendering taxonomy code
115	167	Missing/incomplete/invalid diagnosis or condition
116	23	Adjustment represents the estimated amount the primary payer may have paid
117	22	Override Medicaid Coverage
118	22	Override Retroactive Medicaid
119	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)
120	45	Amount exceeded allowable COB amount
121	185	The rendering provider is not eligible to perform the service billed
123	78	Non-Covered days/Room charge adjustment
125	119	Annual frequency exceeded
126	149	Lifetime frequency exceeded
127	23	The impact of prior payer(s) adjudication including payments and/or adjustments
128	23	Amount in excess of prior payer(s) coinsurance
129	142	Monthly Medicaid patient liability amount
130	2	Coinsurance amount