Claim Adjustment Reason Codes
Currently Valid Codes– January 2009

1	**Deductible Amount** **Start**: 01/01/1995
2	**Coinsurance Amount** **Start**: 01/01/1995
3	**Co-payment Amount** **Start**: 01/01/1995
4	**The procedure code is inconsistent with the modifier used or a required modifier is missing.** **Start**: 01/01/1995
5	**The procedure code/bill type is inconsistent with the place of service.** **Start**: 01/01/1995
6	**The procedure/revenue code is inconsistent with the patient's age.** **Start**: 01/01/1995 | **Last Modified**: 06/30/2002
7	**The procedure/revenue code is inconsistent with the patient's gender.** **Start**: 01/01/1995 | **Last Modified**: 06/30/2002
8	**The procedure code is inconsistent with the provider type/specialty (taxonomy).** **Start**: 01/01/1995 | **Last Modified**: 06/30/2002
9	**The diagnosis is inconsistent with the patient's age.** **Start**: 01/01/1995
10	**The diagnosis is inconsistent with the patient's gender.** **Start**: 01/01/1995 | **Last Modified**: 02/29/2000
11	**The diagnosis is inconsistent with the procedure.** **Start**: 01/01/1995
12	**The diagnosis is inconsistent with the provider type.** **Start**: 01/01/1995
13	**The date of death precedes the date of service.** **Start**: 01/01/1995
14	**The date of birth follows the date of service.** **Start**: 01/01/1995
15	**The authorization number is missing, invalid, or does not apply to the billed services or provider.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
16	**Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 01/01/1995 | **Last Modified**: 06/30/2006

Code	Description
17	**Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 01/01/1995 | **Stop**: 07/01/2009 | **Last Modified**: 09/21/2008
18	**Duplicate claim/service.** **Start**: 01/01/1995
19	**This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
20	**This injury/illness is covered by the liability carrier.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
21	**This injury/illness is the liability of the no-fault carrier.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
22	**This care may be covered by another payer per coordination of benefits.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
23	**The impact of prior payer(s) adjudication including payments and/or adjustments.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
24	**Charges are covered under a capitation agreement/managed care plan.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
26	**Expenses incurred prior to coverage.** **Start**: 01/01/1995
27	**Expenses incurred after coverage terminated.** **Start**: 01/01/1995
29	**The time limit for filing has expired.** **Start**: 01/01/1995
31	**Patient cannot be identified as our insured.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
32	**Our records indicate that this dependent is not an eligible dependent as defined.** **Start**: 01/01/1995
33	**Insured has no dependent coverage.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
34	**Insured has no coverage for newborns.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
35	**Lifetime benefit maximum has been reached.** **Start**: 01/01/1995 | **Last Modified**: 10/31/2002
38	**Services not provided or authorized by designated (network/primary care) providers.** **Start**: 01/01/1995 | **Last Modified**: 06/30/2003
39	**Services denied at the time authorization/pre-certification was requested.** **Start**: 01/01/1995

Code	Description
40	**Charges do not meet qualifications for emergent/urgent care.** **Start**: 01/01/1995
44	**Prompt-pay discount.** **Start**: 01/01/1995
45	**Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).** **Start**: 01/01/1995 | **Last Modified**: 10/31/2006
49	**These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.** **Start**: 01/01/1995
50	**These are non-covered services because this is not deemed a `medical necessity' by the payer.** **Start**: 01/01/1995
51	**These are non-covered services because this is a pre-existing condition** **Start**: 01/01/1995
53	**Services by an immediate relative or a member of the same household are not covered.** **Start**: 01/01/1995
54	**Multiple physicians/assistants are not covered in this case .** **Start**: 01/01/1995
55	**Procedure/treatment is deemed experimental/investigational by the payer.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
56	**Procedure/treatment has not been deemed `proven to be effective' by the payer.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
58	**Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
59	**Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
60	**Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.** **Start**: 01/01/1995 | **Last Modified**: 06/01/2008
61	**Penalty for failure to obtain second surgical opinion.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
66	**Blood Deductible.** **Start**: 01/01/1995
69	**Day outlier amount.** **Start**: 01/01/1995
70	**Cost outlier - Adjustment to compensate for additional costs.** **Start**: 01/01/1995 | **Last Modified**: 06/30/2001

74	**Indirect Medical Education Adjustment.** **Start**: 01/01/1995
75	**Direct Medical Education Adjustment.** **Start**: 01/01/1995
76	**Disproportionate Share Adjustment.** **Start**: 01/01/1995
78	**Non-Covered days/Room charge adjustment.** **Start**: 01/01/1995
85	**Patient Interest Adjustment (Use Only Group code PR)** **Start**: 01/01/1995 | **Last Modified**: 07/09/2007 ***Notes: Only use when the payment of interest is the responsibility of the patient.***
87	**Transfer amount.** **Start**: 01/01/1995
89	**Professional fees removed from charges.** **Start**: 01/01/1995
90	**Ingredient cost adjustment.** **Start**: 01/01/1995
91	**Dispensing fee adjustment.** **Start**: 01/01/1995
94	**Processed in Excess of charges.** **Start**: 01/01/1995
95	**Plan procedures not followed.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
96	**Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 01/01/1995 | **Last Modified**: 06/30/2006
97	**The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
100	**Payment made to patient/insured/responsible party/employer.** **Start**: 01/01/1995 | **Last Modified**: 01/27/2008
101	**Predetermination: anticipated payment upon completion of services or claim adjudication.** **Start**: 01/01/1995 | **Last Modified**: 02/28/1999
102	**Major Medical Adjustment.** **Start**: 01/01/1995
103	**Provider promotional discount (e.g., Senior citizen discount).** **Start**: 01/01/1995 | **Last Modified**: 06/30/2001
104	**Managed care withholding.** **Start**: 01/01/1995

105	**Tax withholding.** **Start**: 01/01/1995
106	**Patient payment option/election not in effect.** **Start**: 01/01/1995
107	**The related or qualifying claim/service was not identified on this claim.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
108	**Rent/purchase guidelines were not met.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
109	**Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.** **Start**: 01/01/1995
110	**Billing date predates service date.** **Start**: 01/01/1995
111	**Not covered unless the provider accepts assignment.** **Start**: 01/01/1995
112	**Service not furnished directly to the patient and/or not documented.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
114	**Procedure/product not approved by the Food and Drug Administration.** **Start**: 01/01/1995
115	**Procedure postponed, canceled, or delayed.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
116	**The advance indemnification notice signed by the patient did not comply with requirements.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
117	**Transportation is only covered to the closest facility that can provide the necessary care.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
118	**ESRD network support adjustment.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
119	**Benefit maximum for this time period or occurrence has been reached.** **Start**: 01/01/1995 | **Last Modified**: 02/29/2004
121	**Indemnification adjustment - compensation for outstanding member responsibility.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
122	**Psychiatric reduction.** **Start**: 01/01/1995
125	**Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
128	**Newborn's services are covered in the mother's Allowance.** **Start**: 02/28/1997
129	**Prior processing information appears incorrect.**

	Start: 02/28/1997 | **Last Modified**: 09/30/2007
130	**Claim submission fee.** **Start**: 02/28/1997 | **Last Modified**: 06/30/2001
131	**Claim specific negotiated discount.** **Start**: 02/28/1997
132	**Prearranged demonstration project adjustment.** **Start**: 02/28/1997
133	**The disposition of this claim/service is pending further review.** **Start**: 02/28/1997 | **Last Modified**: 10/31/1999
134	**Technical fees removed from charges.** **Start**: 10/31/1998
135	**Interim bills cannot be processed.** **Start**: 10/31/1998 | **Last Modified**: 09/30/2007
136	**Failure to follow prior payer's coverage rules. (Use Group Code OA).** **Start**: 10/31/1998 | **Last Modified**: 09/30/2007
137	**Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.** **Start**: 02/28/1999 | **Last Modified**: 09/30/2007
138	**Appeal procedures not followed or time limits not met.** **Start**: 06/30/1999 | **Last Modified**: 09/30/2007
139	**Contracted funding agreement - Subscriber is employed by the provider of services.** **Start**: 06/30/1999
140	**Patient/Insured health identification number and name do not match.** **Start**: 06/30/1999
141	**Claim spans eligible and ineligible periods of coverage.** **Start**: 06/30/1999 | **Last Modified**: 09/30/2007
142	**Monthly Medicaid patient liability amount.** **Start**: 06/30/2000 | **Last Modified**: 09/30/2007
143	**Portion of payment deferred.** **Start**: 02/28/2001
144	**Incentive adjustment, e.g. preferred product/service.** **Start**: 06/30/2001
146	**Diagnosis was invalid for the date(s) of service reported.** **Start**: 06/30/2002 | **Last Modified**: 09/30/2007
147	**Provider contracted/negotiated rate expired or not on file.** **Start**: 06/30/2002
148	**Information from another provider was not provided or was insufficient/incomplete. This change effective 7/1/2009: Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)**

Code	Description
	Start: 06/30/2002 | **Last Modified**: 09/21/2008
149	**Lifetime benefit maximum has been reached for this service/benefit category.** **Start**: 10/31/2002
150	**Payer deems the information submitted does not support this level of service.** **Start**: 10/31/2002 | **Last Modified**: 09/30/2007
151	**Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.** **Start**: 10/31/2002 | **Last Modified**: 01/27/2008
152	**Payer deems the information submitted does not support this length of service.** **Start**: 10/31/2002 | **Last Modified**: 09/30/2007
153	**Payer deems the information submitted does not support this dosage.** **Start**: 10/31/2002 | **Last Modified**: 09/30/2007
154	**Payer deems the information submitted does not support this day's supply.** **Start**: 10/31/2002 | **Last Modified**: 09/30/2007
155	**Patient refused the service/procedure.** **Start**: 06/30/2003 | **Last Modified**: 09/30/2007
156	**Flexible spending account payments** **Start**: 09/30/2003
157	**Service/procedure was provided as a result of an act of war.** **Start**: 09/30/2003 | **Last Modified**: 09/30/2007
158	**Service/procedure was provided outside of the United States.** **Start**: 09/30/2003 | **Last Modified**: 09/30/2007
159	**Service/procedure was provided as a result of terrorism.** **Start**: 09/30/2003 | **Last Modified**: 09/30/2007
160	**Injury/illness was the result of an activity that is a benefit exclusion.** **Start**: 09/30/2003 | **Last Modified**: 09/30/2007
161	**Provider performance bonus** **Start**: 02/29/2004
162	**State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.** **Start**: 02/29/2004
163	**Attachment referenced on the claim was not received.** **Start**: 06/30/2004 | **Last Modified**: 09/30/2007
164	**Attachment referenced on the claim was not received in a timely fashion.** **Start**: 06/30/2004 | **Last Modified**: 09/30/2007
165	**Referral absent or exceeded.** **Start**: 10/31/2004 | **Last Modified**: 09/30/2007
166	**These services were submitted after this payers responsibility for processing claims under this plan ended.** **Start**: 02/28/2005

167	**This (these) diagnosis(es) is (are) not covered.** **Start**: 06/30/2005
168	**Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
169	**Alternate benefit has been provided.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
170	**Payment is denied when performed/billed by this type of provider.** **Start**: 06/30/2005
171	**Payment is denied when performed/billed by this type of provider in this type of facility.** **Start**: 06/30/2005
172	**Payment is adjusted when performed/billed by a provider of this specialty** **Start**: 06/30/2005
173	**Service was not prescribed by a physician.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
174	**Service was not prescribed prior to delivery.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
175	**Prescription is incomplete.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
176	**Prescription is not current.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
177	**Patient has not met the required eligibility requirements.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
178	**Patient has not met the required spend down requirements.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
179	**Patient has not met the required waiting requirements.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
180	**Patient has not met the required residency requirements.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
181	**Procedure code was invalid on the date of service.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
182	**Procedure modifier was invalid on the date of service.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
183	**The referring provider is not eligible to refer the service billed.** **Start**: 06/30/2005
184	**The prescribing/ordering provider is not eligible to prescribe/order the service billed.** **Start**: 06/30/2005
185	**The rendering provider is not eligible to perform the service billed.** **Start**: 06/30/2005

Code	Description
186	**Level of care change adjustment.** **Start**: 06/30/2005 | **Last Modified**: 09/30/2007
187	**Health Savings account payments** **Start**: 06/30/2005
188	**This product/procedure is only covered when used according to FDA recommendations.** **Start**: 06/30/2005
189	**'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service** **Start**: 06/30/2005
190	**Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.** **Start**: 10/31/2005
191	**Not a work related injury/illness and thus not the liability of the workers' compensation carrier.** **Start**: 10/31/2005 | **Last Modified**: 09/30/2007
192	**Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.** **Start**: 10/31/2005 | **Last Modified**: 09/30/2007
193	**Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.** **Start**: 02/28/2006 | **Last Modified**: 01/27/2008
194	**Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.** **Start**: 02/28/2006 | **Last Modified**: 09/30/2007
195	**Refund issued to an erroneous priority payer for this claim/service.** **Start**: 02/28/2006 | **Last Modified**: 09/30/2007
197	**Precertification/authorization/notification absent.** **Start**: 10/31/2006 | **Last Modified**: 09/30/2007
198	**Precertification/authorization exceeded.** **Start**: 10/31/2006 | **Last Modified**: 09/30/2007
199	**Revenue code and Procedure code do not match.** **Start**: 10/31/2006
200	**Expenses incurred during lapse in coverage** **Start**: 10/31/2006
201	**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).** **Start**: 10/31/2006
202	**Non-covered personal comfort or convenience services.** **Start**: 02/28/2007 | **Last Modified**: 09/30/2007
203	**Discontinued or reduced service.** **Start**: 02/28/2007 | **Last Modified**: 09/30/2007

Code	Description
204	**This service/equipment/drug is not covered under the patient's current benefit plan** **Start**: 02/28/2007
205	**Pharmacy discount card processing fee** **Start**: 07/09/2007
206	**National Provider Identifier - missing.** **Start**: 07/09/2007 | **Last Modified**: 09/30/2007
207	**National Provider identifier - Invalid format** **Start**: 07/09/2007 | **Last Modified**: 06/01/2008
208	**National Provider Identifier - Not matched.** **Start**: 07/09/2007 | **Last Modified**: 09/30/2007
209	**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)** **Start**: 07/09/2007
210	**Payment adjusted because pre-certification/authorization not received in a timely fashion** **Start**: 07/09/2007
211	**National Drug Codes (NDC) not eligible for rebate, are not covered.** **Start**: 07/09/2007
212	**Administrative surcharges are not covered** **Start**: 11/05/2007
213	**Non-compliance with the physician self referral prohibition legislation or payer policy.** **Start**: 01/27/2008
214	**Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)** **Start**: 01/27/2008
215	**Based on subrogation of a third party settlement** **Start**: 01/27/2008
216	**Based on the findings of a review organization** **Start**: 01/27/2008
217	**Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)** **Start**: 01/27/2008
218	**Based on entitlement to benefits (Note: To be used for Workers' Compensation only)** **Start**: 01/27/2008
219	**Based on extent of injury (Note: To be used for Workers' Compensation only)** **Start**: 01/27/2008
220	**The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)** **Start**: 01/27/2008

Code	Description
221	**Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)** **Start**: 01/27/2008
222	**Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.** **Start**: 06/01/2008
223	**Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.** **Start**: 06/01/2008
224	**Patient identification compromised by identity theft. Identity verification required for processing this and future claims.** **Start**: 06/01/2008
225	**Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)** **Start**: 06/01/2008
226	**Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 09/21/2008
227	**Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 09/21/2008
228	**Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication** **Start**: 09/21/2008
A0	**Patient refund amount.** **Start**: 01/01/1995
A1	**Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** **Start**: 01/01/1995 | **Last Modified**: 10/31/2006
A5	**Medicare Claim PPS Capital Cost Outlier Amount.** **Start**: 01/01/1995
A6	**Prior hospitalization or 30 day transfer requirement not met.** **Start**: 01/01/1995
A7	**Presumptive Payment Adjustment.** **Start**: 01/01/1995
A8	**Ungroupable DRG.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B1	**Non-covered visits.** **Start**: 01/01/1995

Code	Description
B4	**Late filing penalty.** **Start**: 01/01/1995
B5	**Coverage/program guidelines were not met or were exceeded.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B7	**This provider was not certified/eligible to be paid for this procedure/service on this date of service.** **Start**: 01/01/1995 | **Last Modified**: 10/31/1998
B8	**Alternative services were available, and should have been utilized.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B9	**Patient is enrolled in a Hospice.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B10	**Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.** **Start**: 01/01/1995
B11	**The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.** **Start**: 01/01/1995
B12	**Services not documented in patients' medical records.** **Start**: 01/01/1995
B13	**Previously paid. Payment for this claim/service may have been provided in a previous payment.** **Start**: 01/01/1995
B14	**Only one visit or consultation per physician per day is covered.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B15	**This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B16	**'New Patient' qualifications were not met.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B18	**This procedure code and modifier were invalid on the date of service.** **Start**: 01/01/1995 | **Stop**: 03/01/2009 | **Last Modified**: 09/21/2008
B20	**Procedure/service was partially or fully furnished by another provider.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
B22	**This payment is adjusted based on the diagnosis.** **Start**: 01/01/1995 | **Last Modified**: 02/28/2001
B23	**Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.** **Start**: 01/01/1995 | **Last Modified**: 09/30/2007
D22	**Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code** **Start**: 01/27/2008 | **Stop**: 01/01/2009

W1 **Workers Compensation State Fee Schedule Adjustment**

Start: 02/29/2000