CCI Remittance Mapping

CCI Claim Message Codes	CCI Claim Message Code Description	Mapped Remittance Advice Remark Codes (RARC)	Washington Publishing Company (WPC) Description
8029	Submit to State Medicaid, not a family Care benefit	N30	Patient ineligible for this service.
8030	Auth was for purchase, not rental	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
8032	Please bill correct procedure code per medicare guidelines	M51	Missing/incomplete/invalid procedure code(s).
8033	This line will process under a different DCN	N123	This is a split service and represents a portion of the units from the originally submitted service
8035	Provider not contracted for this code	N448	This drug/service/supply is not included in the fee schedule or contracted legislated fee arrangement.
8036	Please bill the correct modifier	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted
8037	Please bill the revenue or procedure code that was authorized	N761	This provider is not authorized to receive payment for the service(s)
8038	Please provide the manufacturers style & model number	N150	Missing/Incomplete/invalid model number
8039	Please bill the correct place of service	M77	Missing/incomplete/invalid/inappropriate place of service.
8040	Modifer 26 is not valid for medicare reimbursement on this code	N/A	Not used at present
8041	Service description required for miscellenous code	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
8042	Submit charges on HCFA 1500 form	N34	Incorrect claim form/format for this service
8043	Modifier not required for this procedure code	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted
8045	Duplicate claim/line	N1111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated
8046	Charge(s) has been bundled	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
8047	Billed future date(s) of service	N/A	Not used at present
8048	Billed units exceed authorization units	N640	Exceeds number/frequency aprproved/allowd within time period
8049	Billed modifier was not authorized	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted
8050	Service has a different auth, must be billed separately	N61	Rebill services on separate claims
8051	Resubmit with the 5 digit HIPPS code	N471	Missing/incomplete/invalid HIPPS Rate Code.
8052	Per T18 only one type of mammography will be applied	N/A	Not used at present
8053	Billing provider not on file as submitted	N95	This provider type/provider speciality may not bill this service
8054	The submitted EOMB is illegible, resubmit a clear	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The informaiton was either not reported or was illegible.
8055	Type of bill is invalid or missing	MA30	Missing/incomplete/invalid type of bill
8056	Admit diagnosis codes is required	MA65	Missing/incomplete/invalid admitting diagnosis
8057	Admit diagnosis codes is required	N/A	Not used at present
8058	NPI/Taxonomy is not on record with CMS	N521	Mismatch betweeen the submitted provdier information and the provider information stored in our system
8059	Revenue code is incorrect, invalid or missing	M50	Missing/incomplete/invalid revenue code(s).

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8061	Submit Medical records/op-report per UM request	M29	Missing operative note/report.
8062	Submit invoice per UM review	M23	Missing invoice
8063	Billed charges do not match charges submitted	M54	Missing/incomplete/invalid total charges
8064	Submit a valid Medicaid rug	N471	Missing/incomplete/invalid HIPPS Rate Code.
8065	resubmit to primary insurance/medicare	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The informaiton was either not reported or was illegible.
8066	Medicare coinsurance paid in full	N219	Payment based on prayors allowed amount
8068	Service(s) not authorized	N761	This provider is not authorized to receive payment for the service(s)
8069	Resubmit when contract is fully executed	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
8070	Submit Medicare MDS per UM review	N461	Missing Nursing notes
8071	No letter of agreement on file for service dates	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
8072	Resubmit as an observation/outpatient service	N188	The approved level of care does not match the procedure code submitted
8073	NPI is required for rendering provider	N277	Missing/incomplete/invalid other payer rendering provider identifier
8074	Line entered in error (Claim Balancing)	N/A	N/A
8075	Date of service is outside effective dates of the contract	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
8076	Submitted EOB/EOMB does not match submitted claim	N4	Missing/incomplete/invalid prior insurance carrier(s) EOB
8077	Resubmit with provider/location that was authorized	M62	Missing/incomplete/invalid treatment authorization code
8078	Submit charges on a UB-04 form	N34	Incorrect claim form/format for this service
8079	Resubmit with correct diagnosis pointer	M64	Missing/incomplete/invalid/other diagnosis
8080	Non-covered service or supply	N448	This drug/service/supply is not included in the fee schedule or contracted legislated fee arrangement.
8081	Patient status incorrect, invalid or missing	MA43	Missing/incomplete/invalid patient status
8082	Received Medicare EOB and CCI is primary, please verify	N373	It has been determined that another payor paid the services as primary when they were not the primary payor. Therefore, we are funding to the payor that paid as primary on your behalf.
8083	Rendering provider (Box 24J) not on file as submitted	N290	Missing/incomplete/invalid rendering provider primary identifier
8084	TOB XX7 or XX8 and no original claim found	N380	The original claim has been processed, submit a corrected claim.
8085	Present on Admission (POA) indicator is required	N434	Missing/incomplete/invalid present on admission indicator
8086	Primary insurance denied for additional or corrected information	N48	Claim information does not agree with information received from other insurance carrier
8087	Interim rate letter not on file	MA79	Billed in excess of interim rate
8088			
8089	Payment is included in the allowed for a skilled nursing facility (SNF) qualified stay	M80	Not covered when performed during the same session/date for as a previously processed service for the patient.
8090	Submitted documentation is insufficient	N705	Incomplete/invalid documentation
8091	Medicare paid services in full	N219	Payment based on prayors allowed amount

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8092	Service not covered, related to Hospice Care	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
8534	Rehabilitation hospital processing has been applied	N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
8535	Psychiatric hospital processing has been applied	N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
8536	Long term care hospital processing has been applied	N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
8500	Adjusted due to correction of service dates	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8501	Adjusted due to correction of charges	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8502	Adjusted due to correction of revenue/procedure	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8503	Adjusted due to correction of diagnosis code(s)	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8504	Adjustede due to correction of units	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8505	Adjusted due to correction of COB information	N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
8506	Adjusted due to correction of authorization	N758	Adjusted based on the prior authorization decision.
8507	Adjusted due overpayment	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8508	Adjusted due underpayment	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8509	Adjusted due to contract rate change	N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
8510	Adjusted due to incorrect provider	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8511	Adjusted due to incorrect member	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8512	Adjusted due to appeal decision	MA91	This determination is the result of the appeal you filed
8513	Adjusted due to final RUG rate	N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
8514	Adjusted due to subrogation findings	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.

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8515	Refund due to correction of COB information	N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
8516	Refund due to correction of original payment	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8517	Refund due to overpayment	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8518	Adjusted due to correction of modifiers	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8519	Adjusted due to incorrect member plan	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8520	Adjusted due to incorrect claim denial	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8521	Adjsuted due to duplicate payment	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8522	Adjsuted due to rendering provider now on file	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8523	Adjusted due to correction of type of bill	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8524	Adjsuted due to corrction of RUG code	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8525	Adjusted due to internal review	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8526	Adjusted due to lost check	MA74	This payment replaces an early payment for this claim that was either lost damaged or returned
8527	Adjusted to due to correction of place of service	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8528	Adjusted to inpatient DRG HMO pricer	N647	Adjusted based on diagnosis-related group (DRG).
8529	Adjusted due to contract fully executed	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8530	Adjusted due to service description submitted	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8531	Adjusted due to line billed in error	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8537	Adjusted due to correction of NDC	N770	The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.
8538	Adjusted auth signature on file	N758	Adjusted based on the prior authorization decision.