**ANSI AND MOA CODES CURRENTLY USED BY THE REGION B DMERC**

| ANSI Code | ANSI Verbiage |
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| 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. |
| 13 | The date of death precedes the date of service |
| 16 | Claim/service lacks information which is needed for adjudication. |
| 17 | Claim/service denied because requested information was not provided or was insufficient/incomplete. |
| 18 | Duplicate claim/service. |
| 19 | Claim denied because this is a work-related injury and thus the liability of the Worker's Compensation Carrier. |
| 20 | Claim denied because this injury is covered by the liability carrier. |
| 21 | Claim denied because this injury is the liability of the no-fault carrier. |
| 22 | Claim denied because this care may be covered by another payer per coordination of benefits. |
| 23 | Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits. |
| 24 | Payment for charges denied. Charges are covered under a capitation agreement. |
| 26 | Expenses incurred prior to coverage. |
| 28 | Coverage not in effect at the time the service was provided. |
| 29 | The time limit for filing has expired. |
| 30 | Benefits are not available for these services until the patient has met the required waiting or residency period. |
| 31 | Claim denied as patient cannot be identified as our insured. |
| 35 | Benefit maximum has been reached. |
| 38 | Services not provided or authorized by our providers. |
| 42 | Charges exceed our fee schedule or maximum allowable amount. |
| 45 | Charges exceed your contracted/legislated fee arrangement. |
| 46 | This (these) service(s) is (are) not covered. |
| 48 | This (these) procedure(s) is (are) not covered. |
| 50 | These are non-covered services because this is not deemed a "medical necessity" by the payer. |
| 52 | The referring/prescribing provider is not eligible to refer/prescribe/order the service billed. |
| 53 | Services by an immediate relative or a member of the same household are not covered. |
| 55 | Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer. |
| 57 | Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage. |
| 58 | Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| 71 | Primary payer amount. |
| 93 | No Claim level Adjustments. |
| 96 | Non-covered charges. |
| 97 | Payment is included in the allowance for the basic service/procedure. |
| 106 | Patient payment option/election not in effect. |

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| 107 | Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim. |
| 108 | Claim/service denied/reduced because rent/purchase guidelines were not met. |
| 109 | Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor. |
| 110 | Billing date predates service date. |
| 111 | Not covered unless the provider accepts assignment. |
| 112 | Claim/service denied/reduced as not furnished directly to the patient and/or not documented. |
| 113 | Claim denied because service/procedure was provided outside the United States or as a result of war. |
| 114 | Procedure/product not approved by the Food and Drug Administration. |
| 119 | Benefit maximum for this time period has been reached. |
| A2 | Contractual adjustment. |
| A3 | Medicare Secondary Payer liability met. |
| B5 | Claim/service denied/reduced because coverage guidelines were not met or were exceeded. |
| B7 | This provider was not certified for this procedure/service on this date of service. |
| B9 | Services not covered because the patient is enrolled in a Hospice. |
| 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. |
| B11 | The claim has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. |
| B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment. |
| B15 | Claim/service denied/reduced because this procedure/service is not paid separately. |
| B17 | Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. |
| B18 | Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission. |
| B20 | Charges denied/reduced because procedure/service was partially or fully furnished by another provider. |
| B22 | This claim/service is denied/reduced based on the diagnosis. |
| D3 | Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. |
| D4 | Claim/service does not indicate the period of time for which this will be needed. |
| M2 | Not paid separately when the patient is an inpatient. |
| M3 | Equipment is the same or similar to equipment already being used. |
| M4 | This is the last monthly installment payment for this durable medical equipment. |
| M5 | Monthly rental payments can continue until the earlier of the 15$^{th}$ month from the first rental month, or the month when the equipment is no longer needed. |
| M6 | You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15$^{th}$ paid rental month or the end of the warranty period. |
| M7 | No rental payments after the item is purchased. |
| M15 | Separately billed services have been bundled under a single procedure code as |

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| | they are considered components of that same procedure. Separate payment is not allowed. |

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| M25 | Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment. |
| M33 | Claim lacks the UPIN of the ordering physician/referring or performing physician, physician assistant, nurse practitioner, or clinical nurse specialist or the UPIN is invalid. |
| M38 | The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay. |
| M39 | The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements |
| M41 | We do not pay for this as the patient has no legal obligation to pay for this. |
| M43 | Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary. |
| M51 | Incomplete/invalid procedure code(s) and/or rates. This refers to 'not otherwise classified' and 'unlisted' procedure codes too. Refer to the HCFA Common Procedure Coding System. |
| M52 | Incomplete/invalid date(s) of service. |
| M53 | Did not complete or enter the appropriate number (one or more) of days or unit(s) of service. |
| M58 | Please resubmit the claim with the missing/correct information so that it may be processed. |
| M60 | Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form. |
| M61 | We cannot pay for this as the approval period for the FDA clinical trial has expired. |
| M75 | Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment. |
| M76 | Incomplete/invalid patient's diagnosis(es) and conditions. |
| M77 | Incomplete/invalid place of service(s). |
| M78 | Did not complete or enter accurately an appropriate HCPCS modifier(s). |
| M79 | Did not complete or enter the appropriated charge for each listed service. |
| M80 | We cannot pay for this when performed during the same session as a previously processed service for the beneficiary. |
| M83 | Service is not covered unless the beneficiary is under age 50. |
| M87 | Claim/service(s) subjected to CFO-CAP prepayment review. |
| M93 | Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment. |

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| M104 | Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service. |

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| M106 | Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service. |
| M109 | We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation to the referring practitioner. |
| MA01 | If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. |
| MA04 | Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. |
| MA11 | Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources. |
| MA13 | You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient responsibility) group code. |
| MA16 | The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal black Lung Program, P.I. Box 828, Lanha,- Seabrook MD 20703. |
| MA26 | Our records indicate that you were previously informed of this rule. |
| MA59 | The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice. |
| MA67 | Correction to a prior claim. |
| MA72 | The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amounts shown as patient responsibility and as paid to the beneficiary on this notice. |
| MA76 | Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services. |
| MA82 | Did not complete or enter the correct physician/supplier's Medicare billing number/NPI and /or billing name, address, city, state, zip code, and phone number. |
| MA95 | A 'not otherwise classified' or 'unlisted' procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500. |
| MA96 | Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan. |
| MA97 | Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan. |
| MA98 | Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary. |

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| MA102 | Did not complete or enter accurately the referring/ordering/supervising physician's name and/or their UPIN (or surrogate). |
| MA104 | Did not complete or enter accurately the date the patient was last seen and/or the UPIN of their attending physician. |

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| MA130 | Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. |