

Remittance Advice Remarks

The following list of most commonly seen denial codes are posted on the physicians' Remittance Advice. Depending on the code, offices can use this information to correct simple errors through a reopening or by resubmitted a claim.

M13	Only one initial visit is covered per specialty per medical group
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M20	Missing/incomplete/invalid HCPCS code
M24	Missing/incomplete invalid number of doses per vial
M51	Missing/incomplete/invalid procedure code(s)
M52	Missing/incomplete/invalid from date(s) of service
M59	Missing/incomplete/invalid to date(s) of service
M64	Missing/incomplete/invalid other diagnosis
M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate technical and professional components.
M74	This service does not qualify for a HPSA bonus.
M76	Missing/incomplete/invalid diagnosis or condition
M77	Missing/incomplete/invalid place of service
M86	Service denied because payment already made for same/similar service within set time frame.
M90	Not covered more than once in a 12-month period
MA18	Indicates the claim information is also being forwarded to the patient's supplemental insurance.
MA47	Our records show you have opted out of Medicare.
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
N365	This procedure code is not payable. It is for reporting/information purposes only. Typically applies to PQRI claims.
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.
N429	This is not covered since it is considered routine.
N432	Adjustment based on recovery audit



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