Claims adjustments

Adjustment codes and coordination of benefits (COB)

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Electronic submissions

- **Adjustment group codes**
- **Claims adjustment reason codes**

Convert payment information on Explanation of Benefits (EOB) statements into industry-standard coding

Here, you'll find commonly used categories for claims-level and line-level adjustments. You'll also find industry-standard reason codes and group code values.

Include these codes when sending us your secondary claims to provide information on a previous payer's payment. If the previous payer sent a Health Insurance Portability and Accountability Act (HIPAA) standard 835 electronic remittance advice (ERA), you'll see these codes in the ERA. Just transfer them to your secondary claim. If the remittance advice was sent in another form, you'll need to translate that information into these codes.

You can find claims adjustment reason code values and their definitions on the Washington Publishing Company website at **wpc-edi.com**. When a general code is found for a category, we list it in bold. If all that's known about the previous payer's adjustment seems to be related to a category listed on the following pages, then for our purposes, sending the general code listed in bold will usually provide the information needed to resolve the claim. Other codes listed might be applicable if more detail is known about the situation or if the code was sent in an ERA.

Please note: Information contained in this document should be used in conjunction with secondary claims submissions to Aetna. The information contained in this document was not verified with other health insurance companies or with what they need to receive for their secondary claims submissions.

CO = Contractual obligation
OA = Other adjustment
PI = Payer-initiated reductions
PR = Patient responsibility

Category	Claim adjustment group code value	Claim adjustment reason code value(s)
Coinsurance Member's plan coinsurance rate applied to allowable benefit for the rendered service(s).	**PR**	**2, 248**
Exceeds reasonable and customary amount Provider's charge for the rendered service(s) exceeds the reasonable and customary amount.	**PR**	**45**
Deductible Member's plan deductible applied to the allowable benefit for the rendered service(s).	**PR**	**1,** 66, 247
Copayment Member's plan copayment applied to the allowable benefit for the rendered service(s).	**PR**	**3, 241**
Interest amount Patient interest amount. **Note:** Only use when the payment of interest is the patient's responsibility.	**PR**	**85**
Contracted/negotiated rate or reasonable and customary amount Provider's charge either exceeds the contracted or negotiated agreement (rate, maximum exceeds number of hours, days or units) with the payer or exceeds the reasonable and customary amount for the rendered service(s). Use this category when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment that the member is not responsible for, or when the provider's charge exceeds the reasonable and customary amount for which the patient is responsible.	**PR** should be sent if the adjustment amount is the patient's responsibility. **CO** should be sent if the adjustment is related to the contracted and/or negotiated rate. **OA** should be sent only with 271.	24, **45,** 139, 147, 222, 232, 259, 271,* P24, P25, P26 *OA should be sent only with 271. It will not process correctly if it is sent with PR or CO.
Noncovered charge/service denied Provider's charge is not covered by the member's plan.	**PR** should be sent if the adjustment amount is the patient's responsibility. **CO** should be sent if the adjustment is related to the contracted and/or negotiated rate.	19, 20, 21, 35, 29, 39, **45**,* 49, 50, 51, 53, 54, 55, 56, 60, **96**,** 97, 106, 107, 111, 114, 116, 119, 128, 149, 155, 190, 192, 205, 211, 212, 213, 231, 233, 234, 242, 243, 245, 246, 256, 270, 274, 275, 276, 280, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 296, A1, A6, A8, B1, B7, B9, B14, B23, P27 *45 should be sent if the adjustment is related to the contracted/negotiated rate. **96 should be sent if the adjustment amount is the patient's responsibility.

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Category	Claim adjustment group code value	Claim adjustment reason code value(s)
Partial payment/denial Payment was either reduced or denied in order to adhere to policy provisions/restrictions.	**PR** should be sent if the adjustment amount is the patient's responsibility. **CO** should be sent if the adjustment is related to the contracted and/or negotiated rate. **CO** should be sent only with 281.	40, 44, **45**,* 58, 59, 61, 74, 75, 78, 90, 91, 95, **96**,** 102, 104, 105, 108, 112, 115, 117, 118, 121, 122, 130, 132, 134, 137, 143, 144, 150, 151, 152, 153, 154, 157, 158, 159, 160, 163, 164, 169, 173, 174, 175, 176, 186, 193, 194, 197, 198, 202, 203, 210, 223, 236, 238, 249, 250, 251, 252, 253, 261, 269, 272, 273, **281**,*** A7, B4, B8, B10, B15, B16, B20, B22, P28, P29 *45 should be sent if the adjustment is related to the contracted/negotiated rate (CO). **96 should be sent if the adjustment amount is the patient's responsibility (PR). ***CO should be sent only with 281.
Patient not covered by other plan Benefits were not considered by the other payer because patient is not covered or claim was adjusted based on failure to follow prior payer's coverage rules.	**OA**	26, 27, 31, 32, 33, 34, 136, 166, 177, 200, 239, 258 **Note:** If this category applies to the claim/line scenario, the user will need to send the specific code value. See **wpc-edi.com** for code descriptions.
Discount rate Provider offered a discount to member for the service(s) rendered. Member is not responsible for this adjustment.	**OA**	103, **131**
Indian Health Service — patient coinsurance or deductible Per Section 630 of the Medicare Modernization Act (MMA), which permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients. This new reason code enables Medicare to communicate the message that coinsurance or deductible cannot be collected from the patient.	**OA**	209
Already considered by another payer The charge was already considered by a previous payer.	**OA**	**22,** 23
Paid in excess of charge Payment for rendered service(s) exceeds provider's charge.	**PI**	**94**

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Category	Claim adjustment group code value	Claim adjustment reason code value(s)
Partial/full payment from primary payer Payment was either reduced or denied in order to adhere to policy provisions/restrictions.	**CO, PI**	237, 278
Workers' compensation codes The adjustment reason codes listed in this section are used strictly for the adjudication of workers' compensation claims. Secondary claims should not be submitted when a workers' compensation carrier denies benefits using these codes.	**PR** should be sent if the adjustment amount is the patient's responsibility. **CO** should be sent if the adjustment is related to the contracted and/or negotiated rate.	219
Property and casualty codes The adjustment reason codes listed in this section are used strictly for the adjudication of property and casualty claims. Secondary claims should not be submitted when a property and casualty carrier denies benefits using these codes.	**PR** should be sent if the adjustment amount is the patient's responsibility. **CO** should be sent if the adjustment is related to the contracted and/or negotiated rate.	P1, P5, P6, P7, P8, P9, P10, P11, P17, P18, P19, P20, P21,* P22,* P23,* Y3,* 255 *Property and casualty auto only.
Other adjustment reason code values that are not accounted for in this table are: a) Informational messages provided by the payer that do not need to be sent for secondary benefit consideration b) Codes that show corrective action is needed by the provider for the claim and/or service and should not be sent in for secondary benefit consideration until the issue is resolved by the primary payer c) Property/casualty/auto-related codes	Not applicable.	See **wpc-edi.com** list.

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