HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
1	Deductible Amount.	**None**	
1	*Start: 01/01/1995*	**006**	Reduced Deductible
1		**007**	Increased Deductible.
1		**460**	Medicare deductible applied.
1		**500**	Medicare deductible.
1		**D05**	Increased Dental Deductible.
1		**D06**	Decrease Dental Deductible.
2	Co-insurance Amount.	**None**	
2	*Start: 01/01/1995*	**010**	Reduced coinsurance
2		**011**	Increased coinsurance
2		**D09**	Increased dental coinsurance
2		**D10**	Decreased dental coinsurance
3	Co-payment Amount.	**None**	
3	*Start: 01/01/1995*	**004**	Reduced copayment
3		**005**	Increased copayment
3		**69M**	Benefit based on RX co-pay amount.
3		**87M**	Individual responsibility co-pay amount.
3		**899**	Co-pay applied.
3		**901**	Patient is responsible for $10.00 office visit.
3		**904**	Patient is responsible for $4.00 office visit.
3		**D03**	Increased dental copayment
3		**D04**	Decreased dental copayment
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
4	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**514**	The modifier that was billed is invalid for the procedure.
4		**52A**	Denied for criteria not met; required modifier is missing.
4		**52B**	Please resubmit, code is missing modifier or it is invalid for the Therapy service billed.
4		**81R**	Telemedicine services (place of service code 02) must also be billed with an appropriate telemedicine modifier. Corrected claim needed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
4		N27	The modifier that was billed is invalid for the procedure. Please rebill.
4		WHD	The modifier that was billed is invalid for the procedure.
4		n53	Medicare does not allow typical payment adjustments for this procedure code.
4		n59	The professional component modifier 26 is not appropriate with a 100% technical procedure.
4		n82	A required modifier is missing or invalid.
4		t32	Anesthesia code on this line requires an appropriate modifier.
4		t33	Medicare: Professional component modifier needed in place of service for this diagnostic procedure code.
4		t34	Per the MPFS, procedure code describes the physician services. Use of a modifier is not appropriate.
4		t35	Per the MPFS, procedure code describes only the technical portion of a service or diagnostic test. A modifier is not appropriate.
4		t36	Per the MPFS, procedure code describes the global code of a service or diagnostic test. The modifier is not appropriate.
4		t38	Per the MPFS, procedure code describes the physician work portion of a diagnostic test. The modifier is not appropriate.
4		t39	Per Medicare guidelines, procedure code is a service covered incident to a physician's service and modifier is not appropriate.
4		t40	Per Medicare, use of a modifier is not typical for the billed procedure.
4		t49	Per Medicare guidelines, all claim lines on the same claim must contain the modifier EY.
4		t66	Per Medicare, procedure is identified as an ambulance code and requires an ambulance modifier
4		u13	The modifier used is inconsistent with the procedure code.
4		u39	Per NPFS PC/TC indicator, this procedure code is a service covered incident to a physician's service and modifier is not appropriate.
4		u48	A required modifier is missing or invalid.
4		u79	A required modifier is missing or invalid.
4		w27	Per LCD or NCD guidelines, a modifier, which meets medical necessity for the procedure code is missing or invalid.
4		z36	The procedure code requires a modifier 26.
4		z38	Medicare does not allow typical payment adjustments for this procedure code.
4		z52	A modifier on the line is not typical for the procedure code.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
4		z63	The professional component modifier 26 is not appropriate with a 100% technical procedure.
5	The procedure code/bill type is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
5	*Start: 01/01/1995 | Last Modified: 07/01/2017*	515	The procedure code and/or bill type is inconsistent with the place of service.
5		81S	Telemedicine services (modifier GT/GQ/95) must also be billed with place of service 02 (telemedicine). Corrected claim needed.
5		N17	The place of service is inconsistent with the procedure that was performed.
5		WGY	The procedure code, modifier, POS code, and/or bill type is inconsistent with the place of service shown on the claim or in our records.
5		WGy	The procedure code, modifier, POS code, and/or bill type is inconsistent with the place of service shown on the claim or in our records.
5		t37	Per the MPFS, procedure code describes a physician interpretation for service and is not appropriate in place of service.
5		u35	Per the MPFS, procedure code describes a physician interpretation for service and is not appropriate in place of service.
5		u67	Procedure code inconsistent with Place of Service.
5		w16	Billed HCPCS code is not approved for a partial hospitalization claim.
5		w17	Billed HCPCS code can only be billed on a partial hospitalization claim.
5		z49	This claim line is being disallowed because Medicare defines the service to be a non-physician service
5		z64	The place of service is inconsistent with the procedure code.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
6	*Start: 01/01/1995 | Last Modified: 07/01/2017*	9E3	This service is not covered. Not covered for members under age 16.
6		9E4	Covered only for member's under age 19.
6		9E5	This service is not covered. Not covered for members under age 3.
6		9E6	This Service is not covered. Only covered for members age 12 and under
6		9E7	This service is not covered. Not covered for members under age 16.
6		9E8	Not covered for members under age 16.
6		DP0	The service is not allowed due to the patient's age.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
6		N15	This service is not normally performed for members in this age range.
6		N16	This service is not normally performed for members in this age range.
6		OAS	This service is not normally performed for members in this age range.
6		S8	The member's age is beyond the limiting age of the plan.
6		UAS	The member was not covered under the plan on the date the service was provided.
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
7	*Start: 01/01/1995 | Last Modified: 07/01/2017*	ISS	This is not a covered service for this member.
7		w83	Gender conflict; the patient's gender and Other procedure code on the claim are not permissible.
7		y30	This edit occurred because the procedure code includes sex designation and the patient sex does not match
7		z13	This claim line is being disallowed because the procedure code is not typical for the patients gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
8	*Start: 01/01/1995 | Last Modified: 07/01/2017*	578	The procedure code is inconsistent with the provider type/specialty (taxonomy).
8		7AV	Procedure is disallowed because it is typically not assoicated with this specific provider type and speciality.
8		9H4	Procedure code billed is incorrect according to provider specialty. Please re-bill with appropriate anesthesia code.
8		N95	Assistant at Surgery Procedure
8		WHE	The modifier is inconsistent with the provider type/specialty taxonomy).
8		g18	Procedure is disallowed because it is typically not associated with this specific provider type or specialty.
8		n48	This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider
8		u70	Claim contains duplicate diagnosis codes or two diagnosis codes that can't be reported together, per ICD-10-CM Excludes1 note guidelines.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
8		**y98**	This edit occurred because a procedure code has a status indicator of M and not be reported when submitting to the fiscal intermediary
8		**z02**	The procedure code was crosswalked to an appropriate anesthesia code.
8		**z03**	This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider
8		**z09**	The surgical procedure cannot be crosswalked to an anesthesia code because it is by report.
8		**z31**	The procedure can be crosswalked to two or more anesthesia codes so review is required to determine the appropriate code.
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
9	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**w78**	Age conflict; the Admission diagnosis is not permissible for the patient's age.
9		**w79**	Age conflict; the Other diagnoses is not permissible for the patient's age.
9		**w80**	Age conflict; the Principal diagnosis is not permissible for the patient's age.
9		**y24**	This edit occurred because the diagnosis code includes an age range and the patient age is outside of that range
9		**z27**	This claim line is being disallowed because one of the diagnosis codes is not typical for the patients age.
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
10	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**N14**	This service is not covered for this member.
10		**w84**	Gender conflict; the patient's gender and Principal diagnosis code, on the claim are not permissible.
10		**y25**	This edit occurred because the diagnosis code includes sex designation and the patient sex does not match
10		**z35**	This claim line is being disallowed because a diagnosis code is not typical for the patients gender.
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
11	*Start: 01/01/1995 | Last Modified: 07/01/2017*	46M	The diagnosis is inconsistent with the treatment performed. Please resubmit with the corrected diagnosis.
11		46N	The diagnosis code billed is not appropriate for the patient's treatment and/or the service billed.
11		68M	This service and/or type of treatment is not covered for this diagnosis.
11		N19	This service is not covered when performed for the reported diagnosis.
11		t62	The Diagnosis code and modifier combination are inappropriate
11		z28	A diagnosis code on the line is not commonly associated with the procedure code.
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Start: 01/01/1995 | Last Modified: 07/01/2017		
13	The date of death precedes the date of service.	None	
	Start: 01/01/1995		
14	The date of birth follows the date of service.	None	
14	*Start: 01/01/1995*	S2	The date of service is before member's date of birth.
14		524	Please obtain from provider and send itemization of services, showing medical diagnosis, description, and charge for each service.
15	*The authorization number is missing, invalid, or does not apply to the billed services or provider.*	None	
	Start: 01/01/1995 | Last Modified: 09/30/2007 | Stop 5/1/2018		
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16	*Start: 01/01/1995 | Last Modified: 3/1/2018, 07/01/2017*	107	The provider is requested to submit a description of this service/supply.
16		109	Please resubmit with a diagnosis.
16		112	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).
16		114	A valid NDC code is required for physician administered drus covered by the Oregon Health Plan.
16		117	Please resubmit with a valid CPT/HCPCS code.
16		118	No CPT/HCPCS code billed. According to the UB04 manual, this revenue code requires a CPT/HCPCS code. Please resubmit.
16		11E	Please resubmit with a valid CPT/HCPCS code.
16		140	This code is not valid for commercial plans. Code is specific to Medicare or Medicaid plans. Please resubmit with a valid procedure code.
16		48O	Information requested from other provider(s) has not been received.
16		577	Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame.
16		57I	Please provide the patient's height and weight, corrected billing required.
16		57Y	Advantage plans require mileage under 100 miles to be reported to the tenth of a mile.
16		57Z	Please resubmit amblance claim with the point of pick up zip code
16		583	The NDC submitted does not match procedure code submitted. Unable to process. Please submit corrected claim with valid NDC/procedure code.
16		584	NDC lacks unit(s) of measure and/or quantity. Submit corrected claim with valid NDC that includes unit(s) of measure and/or quantity.
16		586	Incorrect code billed. A more appropriate unclassified code or a listed code is available. Resubmit with the correct HCPCS code.
16		58M	Please submit medical records for utilization review of pended days.
16		60A	Provider is requested to submit claim for pricing to: LifeTrac 11100 Waysata Blvd Suite 350, Minneapolis, MN 55305.
16		60I	Provider is requested to submit claim for pricing to: INTERLINK Health Services, 4660 NE Belknap Ct. #209, Hillsboro, OR 97214.
16		60M	Provider is requested to submit claim for pricing to: Cofinity, PO Box 2720, Farmington Hills, MI 48333.
16		60U	Provider submit pricing to OptumHealth Care Solutions. ATTN: Acct. Dept MN010-E133, PO Box 30758, Salt Lake City, UT 84130
16		70J	Please resubmit, Service Facility Location Information is missing or is missing or invalid.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		741	Review. The units billed are invalid because they are not consistent with the procedure code definition.
16		785	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
16		791	A valid NDC code is required.
16		794	A valid NDC code is required.
16		7AS	Please resubmit. Service facility location information is missing or invalid.
16		800	An invalid or wrong code was used. The dentist is requested to submit a correct code.
16		81M	Partial payment only. The remainder of the claim has been returned for additional information.
16		84M	DMAP registration required for payment. Go to https://www.eocco.com/providers/becomeaprovider for an application
16		85M	One or more diagnosis codes on this claim requires more digits to be complete. Please resubmit the claims with a more specific diagnosis.
16		897	Please resubmit with the appropriate ADA code, clinical information, and reason for placement.
16		8A7	This service is not covered. The requested information has not been received from the dentist to confirm need.
16		918	Please submit an invoice for the supply.
16		920	This service is not covered. Chart notes have not been received from the dentist to confirm need.
16		923	An invalid or wrong code was used. The dentist is requested to submit a correct code.
16		970	Lab pathology report is required.
16		992	Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis
16		N78	Invalid diagnosis code
16		WHC	This CPT/HCPCS is not a valid procedure code for the date of service billed. Please resubmit.
16		n29	Only edits for valid modifiers; not specific to outpatient facility claims.
16		n88	The provider specialty information on file is missing or is invalid/incorrect. Contact your provider relations representative for help.
16		n89	Submitted procedure, service, or modifier is inconsistent with the patient's history.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		n90	A related diagnosis code is missing/incomplete/invalid.
16		pa0	A patient reason for visit diagnosis code is required.
16		s01	The patient status is not valid.
16		s02	The patient status code is missing.
16		s08	Procedure code 9672 should not be reported when the patient's length of stay is less than four days.
16		s12	The Principal diagnosis code requires a non-exempt POA indicator of 1 or X.
16		t30	Line item must be submitted with zero or only nominal charge amount.
16		t53	A patient reason for visit diagnosis code is required.
16		u09	Missing/incomplete/invalid value code(s) or amount(s).
16		u22	Missing/incomplete/invalid patient status.
16		u26	Missing/incomplete/invalid discharge or end of care date.
16		u27	Missing/incomplete/invalid occurrence code(s).
16		u28	The combination of modifiers on this line item cannot be used together
16		u32	Missing/incomplete/invalid condition code.
16		u33	There is a conflict with the occurrence, value or condition code and tocedure within the set time frame.
16		u34	Missing/incomplete/invalid/inappropriate place of service.
16		u37	Missing/incomplete/invalid admission source.
16		u38	Missing/incomplete/invalid principal procedure code.
16		u40	Missing/incomplete/invalid other procedure code(s).
16		u42	Partial Hospitalization claims must be submitted in service date sequence. Prior claim not in history.
16		u43	This edit identifies a claim missing a Provider ID. Analysis cannot be performed without a Provider ID
16		u52	A patient reason for visit diagnosis code is required.
16		u54	The first-listed diagnosis code may not be used in the Primary position. (e.g. manifestation diagnosis, "code first" note, or due to POS).
16		u55	A diagnosis is invalid or a required diagnosis is missing for the services on the claim (AKI, RNHCI, ESRD, Hospice, HHRG, etc.)
16		u56	The Present On Admission (POA) indicator is missing or is invalid (e.g. diagnosis designated as POA-exempt).
16		u66	A related diagnosis code is missing/incomplete/invalid.
16		u70	Claim contains duplicate diagnosis codes or two diagnosis codes that can't be reported together, per ICD-10-CM Excludes1 note guidelines.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		u72	A related diagnosis code is missing/incomplete/invalid.
16		u80	This line item contains a revenue code not accepted by this plan.
16		u87	The provider specialty information on file is missing or is invalid/incorrect. Contact your provider relations representative for help.
16		u97	A billed modifier is not appropriate for the type of bill or provider type on the claim.
16		u98	This service is billed using the incorrect claim form or format.
16		w21	Per LCD or NCD, the patient's age does not meet policy requirements for the procedure code and/or a diagnosis code.
16		w26	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
16		w28	Per LCD or NCD, the condition code(s) is missing or does not meet policy requirements for the procedure code
16		w29	Per LCD or NCD guidelines, a primary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.
16		w32	Per LCD or NCD guidelines, a secondary diagnosis code, which meets medical necessity for the procedure code, is missing or invalid.
16		w34	Per LCD or NCD, the revenue code does not meet policy requirements for the procedure code.
16		w57	Age and gender conflict; the Admission diagnosis code is not permissible for the patient's age and gender
16		w58	Age and gender conflict; the Other diagnosis code is not permissible for the patient's age and gender.
16		w59	Age and gender conflict; the Principal diagnosis code is not permissible for the patient's age and gender.
16		w60	The Admission diagnosis code is invalid because it has an incomplete number of digits.
16		w61	The Admission diagnosis code is invalid
16		w62	The Admission diagnosis code is missing
16		w64	The Other diagnosis code is invalid because it has an incomplete number of digits.
16		w65	The Other procedure code must contain a fourth or fifth digit in order to be valid.
16		w67	The Other procedure code must be in the ICD-PSC code Table.
16		w70	The Principal diagnosis code does not contain a complete number of digits.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		w71	The Principal procedure code must be complete in order to be valid.
16		w72	The Principal diagnosis code is not valid based on the 'through' date on the claim.
16		w73	The Principal procedure code must be in the ICD-PSC code Table.
16		w74	The Principal diagnosis code is missing on the claim
16		w76	The Other diagnosis code is a duplicate of the Principal diagnosis code
16		w77	The Other diagnosis code is a duplicate of another Other diagnosis code on the claim.
16		w85	Gender conflict; the patient's gender and Principal procedure code, on the claim are not permissible.
16		w87	Manifestation codes cannot be used as the Principal diagnosis.
16		w89	Diagnosis code is unacceptable as a principal diagnosis unless a required secondary diagnosis is included on the claim.
16		w90	Diagnosis code is unacceptable as a principal diagnosis.
16		w91	An E-code cannot be used as the Admission diagnosis code.
16		w92	An E-code cannot be used as the Principal diagnosis code.
16		w97	Age invalid; Must be in range 0-124 years.
16		w98	The patient gender is missing.
16		w99	The Patient Gender is invalid. Gender must be M, F, or U.
16		y01	The account ID field is missing or invalid
16		y03	This edit occurred because the From (Admission) and Through (Discharge) Dates at the Claim Level are missing or invalid.
16		y04	This edit occurred because the condition code(s) are invalid.
16		y05	This edit occurred because the Patient Discharge Status Code is missing or invalid.
16		y07	This edit occurred because the Type of Bill is missing or invalid.
16		y08	This edit occurred because the claim did not contain the required principle diagnosis code.
16		y09	This edit occurred because the claim did not contain the required principle diagnosis code.
16		y10	This edit occurred because the Patient ID is missing.
16		y11	The DOBf edit identifies a claim that has a missing or invalid DOB. Certain edits cannot be performed without the patient DOB
16		y12	The PSXf edit identifies a claim with a missing or invalid patient gender. Certain edits cannot be performed without the patient gender

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		y15	This edit occurred because the occurrence codes on the claim are invalid
16		y16	This edit occurred because the occurrence span codes on the claim are invalid.
16		y18	This edit occurred because the Type of Admission code is invalid.
16		y23	This edit occurred because the first listed diagnosis field is blank or any diagnosis code is not valid for the service dates on the claim
16		y27	This edit occurred because the first letter of the first listed diagnosis code is an E
16		y28	This edit occurred because the submitted HCPCS code is not valid for the service dates on the claim
16		y39	This edit occurred because multiple exclusive bilat proc codes are present, 2 or more times on the same svc date, with or w/o mod 50
16		y47	Only edits for valid modifiers; not specific to outpatient facility claims
16		y49	Invalid patient age. Based on our records and the From date of service , the patient's age is not between 0 and 24 years.
16		y50	This edit occurred because the age is non-numeric or outside the range of 0-124 years.
16		y67	This edit occurred because the Revenue Code is not in Medicare's list of valid OPPS Revenue Codes
16		y68	This edit occurred because multiple medical visits are present on the same day with the same Revenue Code, without Condition Code G0
16		y72	This edit occurred because TOB 12X or 14X is present with Condition Code 41
16		y86	This edit occurred because mod CA is on more than 1 line with Service Indicator C and same line item DOS or mod CA with multiple units
16		y91	This edit occurred because the line item contains a revenue code not recognized by Medicare
16		y96	This edit occurred because modifier CA has been reported and the patient status code in FL 22 is not 20 (expired)
16		z01	The Account ID is missing.
16		z06	This claim line is being disallowed because there is a missing or invalid beginning or ending date of service (DOS).
16		z08	The place of service (POS) code is missing or invalid.
16		z11	This claim line is being disallowed because the procedure code has been deleted.
16		z12	This claim line is being disallowed because the procedure code is missing or invalid.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		z16	This claim line is being disallowed because the patients date of birth is missing, invalid, or after the date of service.
16		z17	Claim line is being disallowed due to the number of units not mat ching the date span between the beginning and ending dates of service
16		z29	A diagnosis code on the line is invalid.
16		z30	This claim line is being disallowed because there is no primary diagnosis code.
16		z32	This claim line is being disallowed because the diagnosis code requi res a fourth and/or fifth digit to provide appropriate specificity.
16		z33	The claim line contains an inappropriate modifier combination.
16		z51	This claim line is being disallowed because the procedure code is not valid for Medicare.
16		z60	A non-primary diagnosis code was submitted as the primary diagnosis code.
16		z62	This claim line is being disallowed because the patient ID is missing or invalid.
16		z69	The patient gender is missing or invalid.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	None	
18	*Start: 01/01/1995 | Last Modified: 06/02/2013*	CDD	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		Q1	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		Q2	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		Q3	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		n40	This edit occurred because this claim is a possible duplicate of another claim
18		x86	This edit occurred because this claim is a possible duplicate of another claim
18		y19	Identifies line items that are potentially duplicates when two lines entered on one or more claims have identical submitted data
18		y21	Identifies an entire inpatient claim that is a potential duplicate of a previously submitted inpatient claim
18		z15	This claim line is being disallowed because it is a duplicate of another claim line.
18		z18	This claim line is being disallowed because it is an exact duplicate of a claim in history submitted by the same provider.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	**None**	
19	*Start: 01/01/1995 | Last Modified: 09/30/2007*	**67M**	Work related claims are not covered by your plan. Please submit these charges to your Workers' Compensation carrier.
19		**6M7**	Work related claims are not covered by your plan. Please submit these charges to your Workers' Compensation carrier.
20	This injury/illness is covered by the liability carrier.	**None**	
20	*Start: 01/01/1995 | Last Modified: 09/30/2007*	**07M**	Submit to your auto insurance carrier for a determination of their benefits.
20		**153**	No payment is provided because the charge(s) are expected to be paid by the third party liability carrier.
20		**154**	No payment is provided because the charge(s) are expected to be paid out of the third party settlement.
20		**155**	No payment is provided because the charge(s) are expected to be paid by the motor vehicle carrier.
20		**z74**	A diagnosis code on the line is a possible third-party liability.
21	This injury/illness is the liability of the no-fault carrier.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
22	This care may be covered by another payer per coordination of benefits.	**None**	
22	*Start: 01/01/1995 | Last Modified: 09/30/2007*	**57M**	Please send Medicare's explanation of benefits for this claim.
22		**73P**	Coordination of benefits updated; order of benefits changed.
22		**74M**	Please submit a copy of the primary carrier's explanation of benefits. Your claim will be reviewed/adjusted when we received this information.
22		**7A2**	Primary and secondary carriers need to be billed first. Please provide copies of all explanation of benefits for further reivew/adjustment.
22		**86D**	Dental plans are secondary on treatment for accidental injury to the natural teeth. A medical plan's Explanation of Benefits is required.
22		**874**	Please submit a copy of the primary carrier's explanation of benefits. Your claim will be reviewed/adjusted when we received this information.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
22		**CBI**	COB Information not received.
22		**CBN**	Primary Carrier payment Information Required.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	**None**	
23	*Start: 01/01/1995 | Last Modified: 09/30/2007*	**055**	Medicare Supplemental Calculation Applied.
23		**579**	Coverage based on Medicare allowed amount.
23		**580**	The maximum benefit allowance under the non-duplication provisions is our normal benefit less the amount payable under the primary plan.
23		**781**	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
23		**86A**	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
23		**9H3**	Payment has been reduced based on estimation of Medicare's payment. The member may be responsible for the estimated Medicare payment.
23		**COB**	Payment limited due to other insurance
24	Charges are covered under a capitation agreement/managed care plan.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007	**751**	Capitation applied.
25	*Payment denied. The stoploss deductible has not been met.*	**None**	
	Start: 01/01/1995 | Stop: 04/01/2008		
26	Expenses incurred prior to coverage.	**None**	
26	*Start: 01/01/1995*	**S11**	The member's coverage was not in effect on the date service was provided.
26		**S12**	The member's coverage was not in effect on the date service was provided.
26		**S14**	The member's coverage was not in effect on the date service was provided.
26		**S1C**	The member's coverage was not in effect on the date service was provided.
26		**S20**	The date of service is prior to the effective date of coverage.
26		**S21**	The member's coverage was not in effect on the date service was provided.
26		**S22**	The member's coverage was not in effect on the date service was provided.
26		**S23**	The member's coverage was not in effect on the date service was provided.
27	Expenses incurred after coverage terminated.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
27	*Start: 01/01/1995*	**S8**	The member's age is beyond the limiting age of the plan.
27		**S9**	Group no longer eligible.
27		**S10**	The member's coverage was not in effect on the date service was provided.
27		**S17**	The member's coverage was not in effect on the date service was provided.
27		**S1D**	The member's coverage was not in effect on the date service was provided.
27		**S1E**	The member's coverage was not in effect on the date service was provided.
27		**S1F**	The member's coverage was not in effect on the date service was provided.
27		**SD1**	The member's coverage was not in effect on the date service was provided.
27		**SM**	Coverage is no longer in force.
27		**SM1**	The member's coverage was not in effect on the date service was provided.
27		**SO**	Member no longer eligible. Please check ID card.
27		**SQ**	The patient is no longer eligible.
27		**SS**	Member not eligible for benefits.
27		**SW**	Member not eligible for benefits.
29	The time limit for filing has expired.	**None**	
	Start: 01/01/1995	**TF0**	Timely-filing not met. Claim submitted after contract time limit.
29		**972**	Timely- filing not met. Claim submitted after contact time limit.
29		**n03**	The date of service is past Medicare timely filing guidelines.
29		**n35**	The Statement Covers Period Through Date of Service is past the Medicare facility timely filing limit.
29		**t57**	The date of service is past Medicare timely filing guidelines.
29		**w40**	The Statement Covers Period Through Date of Service is past the Medicare facility timely filing limit.
30	*Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.*	*None*	
	Start: 01/01/1995 | Stop: 02/01/2006. Replaced by 177,178,179 & 180		
31	Patient cannot be identified as our insured.	**None**	
31	*Start: 01/01/1995 | Last Modified: 09/30/2007*	**22M**	Our records indicate the patient eligibility is under a plan with dental coverage only.
31		**872**	OEA's records reflect this patient is not covered. Please contact you r school district.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
31		**S7**	Member is over maximum age.
31		**S16**	No plan selection event plan found
31		**S1A**	The member's coverage was not in effect on the date service was provided.
31		**S1B**	The member's coverage was not in effect on the date service was provided.
31		**SB**	Member and spouse only coverage.
31		**SD**	Member and children only coverage.
31		**SE**	Spouse and child only coverage.
31		**SF**	Spouse only coverage.
31		**SG**	Child only coverage.
31		**SL**	Retirees are not covered.
31		**SN**	Patient is not eligible for benefits.
31		**SP**	Eligibility confirmation for this month has not been received.
31		**ST**	The patient is not eligible.
32	Our records indicate the patient is not an eligible dependent.	**None**	
32	*Start: 01/01/1995 | Last Modified: 3/1/2018*	**871**	OEA choice trust shows no proof of dependent status.
32		**S6**	Dependent is over maximum age.
32		**S7**	Member is over maximum age.
33	Insured has no dependent coverage.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007	**SC**	Member only coverage.
34	Insured has no coverage for newborns.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
35	Lifetime benefit maximum has been reached.	**None**	
35	*Start: 01/01/1995 | Last Modified: 10/31/2002*	**L2A**	Lifetime major medical maximum has been met. No further benefits are available.
35		**L2E**	Payment amount has been applied to $500.00 lifetime maximum benefit.
38	*Services not provided or authorized by designated (network/primary care) providers.*	*None*	
	Start: 01/01/1995 | Last Modified: 06/02/2013 | Stop: 01/01/2013 Replaced by 242 and 243		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
39	Services denied at the time authorization/pre-certification was requested.	**None**	
39	*Start: 01/01/1995*	**043**	This Pre-authorization request was denied.
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
40	*Start: 01/01/1995 | Last Modified: 03/01/2017*	**57N**	CMS shows this provider is not currently enrolled in Medicare - Can only allow for Emergent/Urgent care.
40		**57O**	CMS shows this provider is not currently enrolled in Medicare - Can only allow for Emergent/Urgent care.
40		**57U**	Payment to this provider is not allowed per CMS. Please ask your provider for further information.
40		**70E**	Per review, service do not meet medically necessary emergency care.
40		**9I3**	CMS shows this provider is not currently enrolled in Medicare - Can only allow for Emergent/Urgent care.
40		**M13**	Per medical record review, the service does not meet emergency room criteria. Benefit has been made for the assessment fee.
40		**M15**	Per medical record review, the service does not meet emergency room criteria. No benefits issued.
42	*Charges exceed our fee schedule or maximum allowable amount.*	***None***	
	Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 06/01/2007		
43	*Gramm-Rudman reduction.*	***None***	
	Start: 01/01/1995 | Stop: 07/01/2006		
44	Prompt-pay discount.	**None**	
	Start: 01/01/1995		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	**None**	
45	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**002**	Increased allowable-provider.
45		**003**	Reduced allowable-provider.
45		**015**	Increased allowable amount per unit.
45		**017**	Increased allowable-units
45		**03E**	The charge is over the maximum plan allowance for this procedure.
45		**03F**	The charge is over the maximum plan allowance for this procedure.
45		**03M**	The charge is over the maximum plan allowance for this procedure.
45		**067**	Patient liability disallow override.
45		**06M**	This is the case rate payment
45		**103**	NDC code priced.
45		**121**	Exceeds authorized length of stay. No medical necessity established for disallowed day(s).
45		**145**	PHCS provider discount has been applied.
45		**16M**	Please resubmit pharmaceutical with valid NDC# and dosage information.
45		**39M**	Procedure is not included in the provider's contract. Patient not responsible for the balance.
45		**401**	Community Care Network (CCN) provider discount has been applied.
45		**506**	ODS Advantage does not cover this procedure code for women's exams or GYN visits.
45		**507**	Priced with covered G0101. For reconsideration, please send corrected claim using original medicare's coding guidelines.
45		**509**	Requested information not received - Provider.
45		**526**	Coverage based on Medicare allowed amount.
45		**528**	This procedure is not included in the provider's contract. Patient not responsible for the balance.
45		**529**	Your doctor did not accept assignment for this service. Under Federal law, your doctor can not charge more then the patient responsibility

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		530	Diagnosis on claim not covered by Medicare/ODS Advantage. Documentation of prior member notification must be on file before billing member.
45		541	Only in-house staff are approved to perform MTM services under this ODS Advantage plan. Member may not be billed.
45		563	Service/item noncovered by Medicare for the diagnosis. Documentation of prior member notification must be on file before billing member.
45		5M4	This service cannot be paid to this provider type. Not HPSA provider or procedure is statutory exclusion on CMS Physician Fee Schedule.
45		5M5	This service cannot be paid to this provider type. Not HPSA provider or procedure is statutory exclusion on CMS Physician Fee Schedule.
45		70K	Charge over the Oregon Surprise Billing allowed amount cannot be balanced billed
45		70L	Charge over the Oregon Surprise Billing allowed amount cannot be balanced billed
45		718	This procedure is not included in the provider's contract. Patient is not responsible for the balance.
45		750	This service is not covered. The attending dentist does not participate in the ODS/Oregon Health Plan.
45		782	Allowance based on Medicare allowable amount
45		804	This service is not covered. Chart notes have not been received from the dentist to confirm need.
45		83A	The fee charged exceeds the maximum allowance
45		866	Payment is provided for dental treatment performed in the hospital at the same fees as those covered in the dental office.
45		880	Claim processed in accordance with schedule of allowance provided in contract.
45		92M	The charge exceeds the amount allowed by the Oregon Administrative Rule 436-009-0020(1), Bulletin 290, for Oregon Department of Corrections.
45		9A1	The fee charge exceed the maximum allowance.
45		9A6	The charge exceeds the Delta amount allowed.
45		9A8	The charge exceeds the amount allowed.
45		9AN	The fee charge exceed the maximum allowance.
45		9AP	Provider discount has been applied.
45		9B1	Provider discount has been applied.
45		9B9	Services not covered because the patient is enrolled in hospice.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		9C1	The fee charged exceeds the maximum allowance.
45		9C6	The charge exceeds the Delta amount allowed
45		9C8	The charge exceeds the amount allowed.
45		D01	Dental allowable-provider.
45		D02	Dental allowable-patient.
45		D12	Decreased Dental allowable amount per unit.
45		D14	Decreased Dental allowable units.
45		D15	Dental Disallow amount.
45		D21	Deny Ortho Tx
45		E8M	Provider discount has been applied.
45		E8N	Provider discount has been applied.
45		GDM	Processed with ODS contract #111.
		GEM	Processed with ODS contract #999.
45		L71	Benefit limit exhausted; service/item noncovered. ODS Advantage requires documentation of prior member notification before billing member.
45		M01	Increased allowable-patient.
45		M02	Reduced allowable-patient.
45		P62	There are one or more edits present that cause the claim/line to be denied.
45		PAA	The charge exceeds the contracted amount for this service.
45		PAC	This is your Per Case rate.
45		PAF	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
45		PAG	No available APC/Fee schedule rate.
45		PAH	APC Rate.
45		PAK	The charge exceeds the contacted amount for this service.
45		PAL	This is your Per Diem payment.
45		PAP	The charge exceeds the contracted rate for this service.
45		PDA	The charge has been reduced based on a discount arrangement with the provider of service.
45		PDC	Provider discount has been applied.
45		PDD	The charge has been reduced based on a discount arrangement with the provider of service.
45		PDP	The charge has been reduced based on a discount arrangement with the provider of service.
45		PDR	Payment date has been overridden.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		PE0	This is your DRG payment.
45		PEO	The charge exceeds the contracted amount for this service.
45		PEX	External pricing disallow.
45		PFC	The charge exceeds the scheduled R & C amount for this procedure.
45		PFS	The charge exceeds the allowable amount for this service.
45		PFU	The charge exceeds the allowable amount for this service.
45		PFV	The charge exceeds the allowable amount for this service.
45		PFW	The charge exceeds the allowable amount for this service.
45		PGA	The charge exceeds the DRG amount for this confinement.
45		PGD	The charge exceeds the DRG amount for this confinement.
45		PGE	The charge exceeds the DRG rate for this confinement.
45		PGO	The charge exceeds the DRG amount for this confinement.
45		PGP	The charge exceeds the DRG amount for this confinement.
45		PGR	The charge exceeds the DRG amount for this confinement.
45		PMI	Procedure modifier combination invalid or a required modifier is missing.
45		PMP	Price Adjusted Due to Additional Line Item Modifiers.
45		PPC	Exceeds the Ambulatory Payment Classification (APC) rate.
45		PPG	Exceeds APG rate for the line item
45		PSC	The charge exceeds the usual and customary amount for this procedure.
45		PSR	The charge exceeds the allowable rate for this service.
45		TF1	Timely filing not met by the provider. Claim submitted after contract time limit.
45		TR2	The charge exceeds the covered amount for this service.
45		TR3	Covered amount greater than service allowed amount plus related history amount.
45		TR5	Services in excess of benefit maximum.
45		W22	This is the maximum plan allowable under the member's ASO benefit plan
45		W6T	Paid according to your PPO contract with First Choice Network.
45		W7E	Paid accordign to your PPO contract with First Health Network
45		W7F	First Health Travel Network Automated Pricing attempted in the pre-adjudication process.
45		W7H	Paid according to your contract with IPN.
45		n47	This edit occurred because the line item contains C9399, identifying a drug that received FDA approval but does not have a HCPCS assigned
45		n71	Payment reduced based on modifier CT.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		u68	Payment reduced based on modifier CT.
45		y92	This edit occurred because the line item contains C9399, identifying a drug that received FDA approval but does not have a HCPCS assigned
45		z65	This line is eligible for a Assistant/Co/Team Surgery modifier reduction.
45		z78	The procedure code is unlisted.
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
	Start: 01/01/1995 | Last Modified: 07/01/2017		
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
50	*Start: 01/01/1995 | Last Modified: 07/01/2017*	05M	No medical necessity indicated for this service or supply.
50		05R	Benefits previously paid for this supply. No medical necessity indicated for replacement at this time.
50		0M2	Based on Consultant review, medical necessity for the procedure, service or item submitted has not been established.
50		534	Service has been identified as a Never Event and is not eligible for reimbursement.
50		73F	Only initial diagnostic services are covered. Future treatment will be subject to medical necessity.
50		80B	Not medically necessary per Therapeutic Drug Monitorng Criteria.
50		90B	This is not covered. There is no recession or movement of gingival margin.
50		922	Based on consultant review, need was not established. No benefit can be provided.
50		947	Service has been identified as a Never Event and is not eligible for reimburesement.
50		950	These are non-covered services because this is not deemed a "Medical Necessity" by the payer.
50		9G0	Not Medically Necessary per Therapeutic Drug Monitoring Criteria.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
50		N09	The services rendered appear to be cosmetic in nature and not covered under the terms of the plan.
50		Z02	Service was reviewed and determined not to be medically necessary. Services are denied to provider. Do not bill patient.
50		n01	Procedure code is limited coverage code.
50		n02	Procedure codes 02RK0JZ and 02R0JZ are limited coverage when Z006 diagnosis code is present
50		n38	Principal diagnosis code indicates a questionable admission.
50		n43	This edit occurred because the procedure code has a questionable covered svc indicator Medicare will cover only in certain conditions
50		n55	Medicare requires the procedure to have supporting documentation for team surgery.
50		n85	Non-covered services because this is not deemed a 'medical necessity' based on manual review of criteria.
50		s03	Procedure code is limited coverage code.
50		s05	Procedure codes 02RK0JZ and 02RL0JZ are limited coverage when Z006 diagnosis code is present.
50		s06	The Other diagnosis code indicates that a wrong procedure was performed.
50		s07	The Principal diagnosis code indicates that a wrong procedure was performed.
50		t30	Line item must be submitted with zero or only nominal charge amount.
50		t46	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
50		t48	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
50		t54	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
50		u36	These are non-covered services because this is not deemed a "Medical Necessity" by the payer.
50		u82	Non-covered services because this is not deemed a 'medical necessity' based on manual review of criteria.
50		w19	This service was provided after the end date of coverage for the NCD
50		w23	Per LCD or NCD guidelines, procedure code has a denied relationship.
50		w24	Per LCD or NCD, the frequency does not meet policy requirements for the procedure code

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
50		w33	Per LCD or NCD guidelines, a tertiary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.
50		w88	Principal diagnosis code indicates a questionable admission.
50		y34	This edit occurred because the procedure code has a questionable covered svc indicator Medicare will cover only in certain conditions
50		y94	This edit occurred because the item, service, or procedure was admin istered or performed prior to the eff date as specified in the NCD
50		z98	LCD/ NCD: Patients gender does not meet policy requirements
51	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
51	*Start: 01/01/1995 | Last Modified: 07/01/2017*	17M	Individual Contestability Exclusion
51		18M	Pre-existing condition not covered for period specified by the plan. The member has not provided creditable coverage information.
51		40M	Pre-existing condition not covered for period specified by the plan. The member has not provided creditable coverage information.
51		906	Pre-existing conditions are not covered.
52	*The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.*	None	
	Start: 01/01/1995 | Stop: 02/01/2006. Replaced by 170, 183, 184 & 185.		
53	Services by an immediate relative or a member of the same household are not covered.	None	
	Start: 01/01/1995		
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
54	*Start: 01/01/1995 | Last Modified: 07/01/2017*	N06	This procedure does not normally require the services of an assistant surgeon.
54		WGA	The nature of this surgical procedure does not normally require the services of an assistant surgeon.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
54		n20	Procedure code does not normally require Assistant Surgeon. Reconsider ation requires manual review of records for special circumstances.
54		n28	Medicare requires the procedure to have supporting documentation for an assistant surgeon.
54		n54	Medicare requires the procedure to have supporting documentation for a co-surgeon.
54		n57	This claim line is being disallowed because team surgeons are not permitted with this procedure code per Medicare.
54		n86	Procedure code requires supporting documentation for a co-surgeon to allow, per CMS.
54		n87	Procedure code requires supporting documentation for team surgeons to allow, per CMS.
54		u06	Claim line is being disallowed because Medicare typically does not allow reimbursement for surgical assistants on this procedure code.
54		u15	This claim line is being disallowed because Medicare typically does not allow reimbursement for co-surgeon on this procedure code.
54		u29	This claim line is being disallowed because Medicare does not allow reimbursement for Team surgeons on this procedure code.
54		u57	Procedure code does not normally require Assistant Surgeon. Reconsideration requires manual review of records for special circumstances.
54		u83	Procedure code requires supporting documentation for a co-surgeon to allow, per CMS.
54		u84	Procedure code requires supporting documentation for team surgeons tollow, per CMS.
54		z37	Claim line is being disallowed because Medicare typically does not allow reimbursement for surgical assistants on this procedure code
54		z41	This claim line is being disallowed because Medicare typically does not allow reimbursement for co-surgeon on this procedure code.
54		z42	Medicare requires the procedure to have supporting documentation for an assistant surgeon.
54		z43	Medicare requires the procedure to have supporting documentation for a co-surgeon.
54		z44	Medicare requires the procedure to have supporting documentation for team surgery

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
54		**z56**	This claim line is being disallowed because team surgeons are not permitted with this procedure code per Medicare.
54		**z71**	This claim line is being disallowed because only one surgical assistant is allowed per procedure code.
54		**z72**	This claim line is being disallowed because the procedure code does not typically allow an assistant surgeon modifier.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
55	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**517**	Experimental or investigational services and/or supplies are not covered.
55		**701**	This procedure is considered experimental in nature and not a covered service under the plan
55		**9H8**	Investigational care costs associated with clinical trial participation are not covered.
55		**9I1**	Service is considered experimental/investigational and not covered under this plan. Services are denied to provider. Do not bill patient.
55		**N10**	This procedure is considered experimental in nature and not a covered service under the plan
55		**Z01**	Service is considered experimental/investigational and not covered under this plan. Services are denied to provider. Do not bill patient.
55		**z80**	
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 01/01/1995 | Last Modified: 07/01/2017	**814**	Based on consultant review treatment does not have good long term outcome.
57	*Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.*	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Start: 01/01/1995 | Stop: 06/30/2007 Split into codes 150, 151, 152, 153 and 154		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 01/01/1995 | Last Modified: 07/01/2017	**y40**	This edit occurred because the proc has been designated by Medicare as paystatus "C", the proc is not covered when performed as outpt
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
59	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**048**	The allowable amount for this service has been reduced according to ASC multiple procedure guidelines.
59		**049**	The allowable amount for this service has been reduced according to ASC default category guidelines.
59		**056**	Allowance reduced based on Multiple Surgery guidelines.
59		**761**	Claim review results. Multiple surgery fee reductions apply to this code.
59		**9C9**	Allowance reduced based on Multiple Surgery guidelines.
59		**WGQ**	Allowance reduced based on Multiple Surgery guidelines.
59		**WGR**	Allowance based on bilateral fee adjustment rules.
59		**WGS**	Procedure not eligible for bilateral fee adjustments; procedure inherently bilateral per Physician Fee Schedule or code definition.
59		**WHH**	The presence of an anesthesia modifier indicates a reduction in paymen
59		**n11**	Procedure code and history procedure code indicate multiple imaging services; reduction applied.
59		**n12**	Procedure code and history procedure code indicate multiple imaging services; reduction applied.
59		**n14**	A multiple procedure reduction of 50% of the allowed amount should be applied to this claim line
59		**n15**	Medicare requires that an operative report be reviewed when more than 5 procedures have been performed on the DOS

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
59		n16	A multiple procedure reduction of 50% of the allowed amount should be applied to History Claim
59		n26	Procedures indicate multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies.
59		n27	Procedures indicate that multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies to history.
59		n50	This line is eligible for a Bilateral Procedure Reduction.
59		n76	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line.
59		n79	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line.
59		t11	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
59		t12	Procedure code and history procedure code indicate multiple imaging services; reduction applied.
59		t13	Procedure code and history procedure code indicate multiple imaging; reduction applied.
59		t16	Procedure qualifies for multiple endoscopy reduction and payment should be reduced. RVU value for this line should be reduced.
59		t17	For procedure code and history code a multiple endoscopy reduction applies to the history claim and payment should have been reduced
59		t19	A multiple procedure reduction of 50% of the allowed amount should be applied to this claim line.
59		t20	Medicare requires that an operative report be reviewed when more than 5 procedures have been performed on the DOS.
59		t21	A multiple procedure reduction of 50% of the allowed amount should be applied to History Claim.
59		t68	Procedures indicate multiple imaging services were performed; reduction applies.
59		t69	Procedures indicate that multiple imaging services were performed; reduction applies.
59		u73	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line.
59		u76	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
59		**u85**	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line
59		**u86**	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line
59		**u88**	Per Medicare guidelines, a multiple procedure reduction should be applied to this claim line
59		**w44**	Procedure code is retained from the transfer relationship
59		**z07**	This line is eligible for a Bilateral Procedure Reduction.
59		**z53**	Submitted procedure, service, or modifier is inconsistent with the patient's history.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	**None**	
	Start: 01/01/1995 | Last Modified: 06/01/2008		
61	Adjusted for failure to obtain second surgical opinion.	**None**	
	Start: 01/01/1995 | Last Modified: 03/01/2017		
62	*Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.*	**None**	
	Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 04/01/2007		
66	Blood deductible.	**None**	
	Start: 01/01/1995	**52N**	Per your plan the first 3 pints of blood, per calndar year, are not covered.
69	Day outlier amount.	**None**	
	Start: 01/01/1995		
70	Cost outlier - Adjustment to compensate for additional costs.	**None**	
	Start: 01/01/1995 | Last Modified: 06/30/2001	**OUT**	Outlier Pricing.
74	Indirect Medical Education Adjustment.	**None**	
	Start: 01/01/1995		
75	Direct Medical Education Adjustment.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Start: 01/01/1995		
76	Disproportionate Share Adjustment.	**None**	
	Start: 01/01/1995		
78	Non-covered days/room charge adjustment.	**None**	
	Start: 01/01/1995	**124**	Plan allows up to semi-private room rate.
85	Patient Interest Adjustment (Use Only Group code PR)	**None**	
	Start: 01/01/1995 | Last Modified: 07/09/2007		
87	*Transfer amount.*	**None**	
	Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 01/01/2012		
88	*Adjustment amount represents collection against receivable created in prior overpayment.*	***None***	
	Active: 1/1/95 | Deactivated: 6/30/07		
89	Professional fees removed from charges.	**None**	
	Start: 01/01/1995		
89		**WGZ**	This automated lab test is not eligible for separate professional payment.
89		**WGz**	This automated lab test is not eligible for separate professional payment.
90	Ingredients cost adjustments. Usage: To be used for pharmaceuticals only.	**None**	
	Start: 01/01/1995 | Last Modified: 07/01/2017		
91	Dispensing fee adjustment.	**None**	
	Start: 01/01/1995		
94	Processed in Excess of charges.	**None**	
94	*Start: 01/01/1995*	**PAI**	The charge exceeds the contracted amount for this service.
94		**PAR**	The charge exceeds the contracted amount for this service.
95	Plan procedures not followed.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
96	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**03D**	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
96		**044**	This request for a referral was denied.
96		**065**	This is not a covered HRA service.
96		**066**	Not covered under Medical Plan--to be paid as 'HRA Only' service.
96		**068**	No Pledge Amount for this HealthCare Expense.
96		**069**	No Pledge Amount for the Dependent Care Expense.
96		**073**	Deny All Claim Lines.
96		**122**	The plan allows preventive health care benefits only when services are provided by the Primary Care Physician (PCP).
96		**141**	The service is not covered. Our records indicate another provider is the primary chemical dependency provider for this service.
96		**144**	The diagnosis and treatment pair is below the line as defined on the prioritized list of covered services.
96		**170**	Services received within 60 days from the last service are not covered. Please check you records.
96		**513**	Service/item noncovered by CMS and ODS Medicare Advantage. Documentation of prior member notification must be on file before billing member.
96		**520**	Service not covered. The provider has chosen (opted out) or is not allowed (sanctioned) to bill Medicare for services/test/supplies.
96		**523**	The covered portion of this item/service is billed under another code. This portion/upgrade feature is not covered under your plan.
96		**525**	The services provided to you in a Veterans Affairs (VA) facility are not covered by ODS Advantage because criteria listed in Evidence of Cov.
96		**57P**	Service not covered. The provider has chosen (opted out) or is not all allowed (sanctioned) to bill Medicare for services/tests/supplies.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		57R	Payment to this provider is not allowed per CMS. Please ask your provider for further information.
96		57W	Routine vision care provided by VSP please call 1-844-693-8863
96		581	Medicare does not pay for this equipment, item, or service. Provider indicates member was informed in writing that this was not covered.
96		582	Denied because Medicare only covers this under certain circumstances. Claim indicates member was informed in writing this was not covered.
96		70A	Claim processed for encounter purposes only. This provider is not part of the ODS network.
96		73B	The total billed units for this procedure are medically unlikely.
96		73M	Only charges for initial diagnostic services are covered. Your plan excludes expense for treatment of this condition.
96		744	Replacement of a space maintainer is not a covered benefit when lost, stolen or damaged.
96		74N	Routine vision care provided by VSP please call 1-844-693-8863
96		764	Claim review results. These items are supplies which cannot be billed as implants. Corrected claims not accepted.
96		78N	Claim review results: Observation services beyond 48 hours are denied.
96		809	Benefit is provided for fluoride once every six months up through the age of 18.
96		80C	This service is not covered. The buildup on this tooth is not covered because the final restoration is not covered.
96		80E	This kind of medicine is not covered.
96		80P	Based on our contract with Lane County this service is not covered. This member has a primary care dentist.
96		810	Benefit is provided for examination, bitewing x-rays and one prophylaxis (including scaling and curettage) in each six month period.
96		811	Payment is provided for a complete series x-rays (including panoramic) once in a three year period.
96		812	Payment for an examination fee includes the use of diagnostic aids, except for x-rays, study models and certain lab test.
96		813	Payment is provided for study models for cases involving three or more missing teeth (not full dentures). Limited to one every five years.
96		816	Payment is provided for a single surface restoration in each episode of treatment regardless of the number of restorations placed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		819	Preparation of gingival tissue for placing a restoration should be included in the fee for the restoration.
96		81I	The service is not covered when taking out the tissue that joins the upper gums to the lip. Also, you are not the age of 12 to 21 years old.
96		81Y	Implants, implant related services and copings are not covered.
96		82X	Retainer adjustments are considered part of the initial treatment. Benefits are not covered.
96		831	No payment is provided for fixed bridges or removable cast partials for patients under the age of 16.
96		832	Payment is provided for stayplates, temporary partials, or temporary bridges only to replace recently extracted anterior teeth.
96		835	Based on our records this tooth is missing.
96		83D	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
96		841	Payment is provided for fixed bridge abutment restorations as part of the prosthetic benefit regardless of the condition of the abut. Teeth
96		856	Payment is provided for general anesthesia only in conjunction with covered surgical procedures performed in a dental office.
96		85A	Sealant repairs are not covered.
96		85B	Specialized and experimental techniques or precision attachments are not covered.
96		865	Payment is not provided for hospitalization, including hospital visits and procedures.
96		868	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
96		870	Payment is not provided for incomplete treatment. Please file on the completion date.
96		882	Appliances, restorations or procedures are not payable when done to increase vertical dimension.
96		885	Appliances, restorations or procedures are not payable when done to realign teeth.
96		886	Appliances, restorations or procedures are not payable when done to treat disturbances of the TMJ and associated structures.
96		887	Appliances, restorations or procedures are not payable when done for cosmetic reasons.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		890	Appliances, restorations or procedures are not payable when done to correct habits.
96		8C3	This is not covered. Replacing a space maintainer is not covered.
96		8D5	Service is not covered on this tooth.
96		924	Based on our records this tooth is missing.
96		926	The root canal on this tooth is not covered because the final repair is not covered.
96		959	Procedure is not covered for this tooth.
96		976	Implants are not covered. Implants may be covered by a separate plan offered through ILWU-PMA Benefit Plans. For details call 415-673-8500.
96		998	Temporary treatment not covered.
96		9AQ	Non Covered. Modifier GA/GX indicates you prior-informed member in writing services would not be covered & member signed agreement to pay.
96		9AT	Our records show there is no missing front tooth or six or more back teeth.
96		9B0	This is not covered. Teeth were pulled more than 6 months ago.
96		9C0	Not a covered service. Our records show there are not enough missing teeth.
96		9G8	Specialized and experimental techniques or precision attachments are not covered.
96		9H1	Retainer adjustments are considered part of the initial treatment. Benefits are not covered.
96		9H5	Self-administered medications are excluded when not provided by a pharmacy; covered only through the prescription medication benefits.
96		9H6	Self-administered medications are excluded when not provided by a pharmacy; covered only through the prescription medication benefits.
96		9H9	Statutorily non-covered. Medicare does not pay for this item or service.
96		9I2	Statutorily non-covered. Medicare does not pay for this item or service.
96		A00	Services provided are not a covered benefit with ODS Advantage.
96		C02	Place of service on claim does not match authorization. Based on contractual guidelines, the claim is denied.
96		C03	Place of service on claim does not match authorization. Based on contractual guidelines, claim is denied.
96		DP1	Procedure is not covered for this tooth.
96		E05	Payment is provided only for charges by a licensed dentist.
96		E68	Paymet is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		E98	OHP Prioritized List-Matched by Dx Only
96		MLN	Please submit the primary diagnosis.
96		PS0	This service is not covered under the plan.
96		PS3	Non-covered benefit. Non-participating provider.
96		S5	Member has no coverage for this date of service or benefit type.
96		TR1	This is not a covered service under the plan.
96		WGX	The total billed units for this procedure are medically unlikely.
96		Z06	Determined to be a contract exclusion. Services are denied to provider. Do not bill patient.
96		n05	Procedure code with an allowed daily frequency has been exceeded.
96		n06	LCD/ NCD: provider specialty does not meet policy for procedure code.
96		n09	LCD/ NCD: Documentation should be requested or reviewed.
96		n21	Per Medicare, in the absence of injury or direct exposure, preventive immunization and its administration is not covered.
96		n23	Per Medicaid Medically Unlikely Edits, the units of service billed for the procedure code exceed the allowed number of units.
96		n30	Per LCD or NCD guidelines, documentation should be requested or reviewed for the procedure code.
96		n31	Per LCD or NCD, the type of bill does not meet policy requirements for the procedure code.
96		n32	Per LCD or NCD, the value code(s) is missing or does not meet policy requirements for the procedure code.
96		n42	This edit occured because the claim was submitted with Condition Code 20
96		n62	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
96		n67	The units have exceeded the allowable maximum frequency per time span
96		n68	The units of service exceeds the acceptable maximum.
96		t03	LCD/ NCD: provider specialty does not meet policy for procedure code.
96		t07	LCD/ NCD: Procedure code has a denied relationship.
96		t08	LCD/ NCD: Procedure code is a profiled relationship. Please review
96		t09	LCD/ NCD: Documentation should be requested or reviewed
96		t18	The maximum frequency for procedure code has been exceeded.
96		t23	Procedure code is a non-covered service per the Non-covered Service list.
96		t43	Per Medicare guidelines, the maximum frequency for the DME procedure code has been exceeded.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		t44	Per Medicare guidelines, the maximum frequency for the DME procedure code has been exceeded.
96		t51	The presence of modifier GY indicates this is not eligible for payment.
96		t52	Per Medicare guidelines, the procedure code is a non covered code or the modifier is a non covered modifier.
96		t55	Per Medicare, in the absence of injury or direct exposure, preventive immunization and its administration is not covered.
96		t58	Per Medicaid Medically Unlikely Edits, the units of service
96		t65	The frequency of the procedure code has exceeded the allowable maximum frequency for this code
96		t67	The presence of modifier GZ indicates this is not eligible for payment.
96		u05	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
96		u17	Non-covered service. CMS permits network providers to bill members if a pre-service determination was requested from Moda and was denied.
96		u19	The units of service exceeds the acceptable maximum.
96		u24	The units have exceeded the allowable maximum frequency per time span.
96		u25	The units of service exceeds the acceptable maximum.
96		u49	The patient's age conflicts with a submitted diagnosis code.
96		u50	The patient's age conflicts with procedure code.
96		u51	The reported diagnosis does not meet coverage criteria for the service
96		u59	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
96		u64	The units have exceeded the allowable maximum frequency per time span
96		u65	The units of service exceeds the acceptable maximum.
96		w25	Per LCD or NCD, the patient's gender does not meet policy requirements for the procedure code and/or a diagnosis code.
96		w30	Per LCD or NCD guidelines, procedure code has a profiled relationship. Please review the policy.
96		w31	Per LCD or NCD guidelines, documentation should be requested or reviewed for the procedure code
96		w35	Per LCD or NCD, the type of bill does not meet policy requirements for the procedure code.
96		w36	Per LCD or NCD, the value code(s) is missing or does not meet policy requirements for the procedure code.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		w37	Per Medicaid Medically Unlikely Edits, the units of service billed for the procedure code exceed the allowed units
96		w93	A non-covered over age 60 ICD procedure code is on the claim and the patient is older than 60 years of age.
96		w94	Procedure code is non-covered when a designated diagnosis code is present.
96		w95	Procedure code is non-covered unless the exemption ICD-9 Procedure code or exemption ICD Diagnosis code is present.
96		x82	Units > 1 for bilateral procedure with modifier 50
96		y33	This edit occured because the claim was submitted with Condition Code 20
96		y52	This edit occurred because the proc code indicator Not Recognized by Medicare-OPPS. Medicare will not accept code, but may accept alternate
96		y53	This edit occurred because the principal diagnosis is not related to mental health on a partial hospitalization claim
96		y54	This edit occurred because APC 323, 324, or 325 is present and three or more qualifying critera are present
96		y76	This edit occurred because a claim line contains a CPT/HCPCS code which is non-covered by Medicare based on statute
96		y88	This edit occurred because proc is not reportable on an OPPS claim but may be accepted for other types of claims
96		y95	This edit occurred because the item, service, or procedure was admin istered or performed outside a clinical trial period approved by CMS
96		z45	Procedure code with an allowed daily frequency has been exceeded
96		z61	This claim line is being disallowed because a new patient E&M service was billed for an established Patient.
96		z79	This claim line is being disallowed because the procedure code is considered cosmetic.
96		z88	LCD/ NCD: Diagnosis code(s), for procedure code is missing or invalid
96		z89	LCD/ NCD: A modifier for procedure code is missing or invalid
96		z91	LCD/ NCD: A primary diagnosis code is missing or invalid
96		z92	LCD/ NCD: A secondary diagnosis code is missing or invalid
96		z93	LCD/ NCD: A tertiary diagnosis code which meets medical necessity for procedure code is missing or invalid.
96		z95	LCD/ NCD: Frequency does not meet policy requirements for procedure code.
96		z97	LCD/ NCD: POS does not meet policy requirements for procedure code
96		z99	LCD/ NCD: Age does not meet policy requirements for procedure or DX

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Start: 01/01/1995 | Last Modified: 07/01/2017	133	Negotiated package rates are all-inclusive. Provider is requested to contact the hospital regarding payment.
97		2M0	Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service.
97		503	No separate payment can be made for this service. This is a Medicare bundled/excluded code.
97		512	This service or supply is included in the payment for another service.
97		706	Time documented is less than eight minutes. Service is not separately reimbursable. Does not meet requirements of 8-minute rule.
97		707	Benefits for miscellaneous charges are included in the payment for the base rate.
97		709	Audit results. This service is a component of a more comprehensive and/or global service and should not be reported separately.
97		711	This service is not eligible on the day of discharge.
97		721	The surfaces must be combined and billed, one line per tooth, using appropriate code.
97		73C	Service denied because billed outside of the time-frame requirements for a similar or related service already allowed.
97		752	Claim review results. This item not eligible to be separately reported or never eligible for separate reimbursement
97		753	Claim review results. The payment for this service is included in the fee for one of the other services already allowed.
97		754	Claim review results. This service is always included in another service already allowed. This edit is never eligible for a modifier bypass.
97		755	Review results. Requirements for separate and distinct service allowance and/or modifier not met. Included in allowance for another service.
97		771	Claim review results. Item(s)/services identified as not eligible to be separately reported or never eligible for separate reimbursement.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		773	Review results. Documentation does not support modifier 58/79. Service determined to be related to previous surgery & allowance reduced.
97		774	Claim review results. Service has been determined to be part of the Global Surgical Package. No separate reimbursement can be made.
97		77M	Benefits for miscellaneous charges are included in the payment for the base rate.
97		788	Review. Outpatient services related to inpatient services; not separately billable. Charges are included in inpatient reimbursement.
97		789	Review. Readmission within set time frame from discharge may not be billed separately. Included in Inpatient reimbursement.
97		7C8	DRG review using the readmission claim information has reassigned the DRG on the combined claims.
97		802	Retreatment of root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment fee.
97		806	This service is included in other services on this claim, treatment date or tooth.
97		807	Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee.
97		80J	This service is not covered. Adjustments and repairs to dentures are not covered within 6 months of receiving the denture.
97		80K	A separate payment is not provided for dental surgery that shapes the bone that supports the teeth in conjunction with removal of teeth.
97		80L	A separate payment is not provided for dental surgery that shapes the bone that supports the teeth in conjunction with removal of teeth.
97		80N	This service or supply is included in the payment for another service.
97		80Q	Benefit limited within 6 months.
97		80U	Medicine to stop caries is included in the fee for the filling or crown.
97		80V	Medicine to stop caries is included in the fee for the filling or crown.
97		80W	Gluing a post and core the same day as gluing the crown cannot be billed to the patient.
97		80X	When done on the same day as other pulpal treatment this cannot be billed to the patient.
97		80Y	A post and core cannot be billed to the patient when done the same day as a filling.
97		80Z	Translating or sign language is part of the appointment

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		819	Preparation of gingival tissue for placing a restoration should be included in the fee for the restoration.
97		81G	The fee for this service is included in the fee for the exam.
97		81P	This service is not covered. Adjustments and repairs to dentures are not covered within 6 months of receiving the denture.
97		820	A separate, additional payment is not provided for tooth preparation,temporary treatment, bases, impressions or local anesthesia.
97		821	Payment is provided for pulp capping when there is exposure of the pulp. We do not predetermine this expense.
97		82B	Repairs done within 24 months of the intial placement are considered part of the initial restoration fee.
97		82E	Full series x-rays and single x-rays billed on the same day are considered a complete series.
97		82F	A Build-Up is only a benefit when needed to hold a crown in place.
97		82G	A build up is part of a build up post.
97		82H	More than one deep cleaning done on the same day and in the same area is reimbursed as one cleaning.
97		82I	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		82J	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		82K	More than one deep cleaning done on the same day and in the same area is reimbursed as one cleaning.
97		82L	This gum treatment is included in other gum treatment in the same area.
97		82M	This gum treatment is included in other gum treatment in the same area
97		82N	Full series x-rays and single x-rays billed on the same day are considered a complete series.
97		82O	Cone beam capture is included in the fee for taking and reading the image.
97		82P	MRI capture is included in the fee for taking and reading of the image
97		82Q	The charge for the ultrasound is part of the fee for taking and reading the image.
97		82R	Reading an image is part of the fee for taking and reading the image.
97		82T	Full series x-rays and single x-rays billed within 60 days are considered a complete series.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		82U	Full series x-rays and single x-rays billed within 60 days are considered a complete series.
97		82V	Only one fee for Nitrous oxide is allowed on the same day.
97		837	Reline is included in the amount of payment provided for the complete replacement of a denture base (jump) fee.
97		83E	Charges to remove tissue from around the tooth is limited to once for the same space.
97		83F	Charges to remove tissue from around the tooth is limited to once for the same space.
97		83G	Closing the hole in the sinus is part of the surgical extraction.
97		83H	Closing the hole in the sinus is part of the surgical extraction.
97		83I	A biopsy done at the same time as surgery is part of the surgery.
97		83J	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		83K	This gum treatment is included in other gum treatment in the same area
97		83L	Deep cleaning below the gums done twice in the same area is combined to one deep cleaning.
97		83N	The surgery on this tooth is included in the root canal.
97		83O	This type of filling is part of the restoration
97		83P	An x-ray that shows the whole mouth in one film is part of a full moutH X-RAY.
97		83Q	Suturing a wound is part of the tooth removal. It is also part of a related surgery.
97		83R	Fixing a surgery within 3 years is part of the first surgery.
97		83S	This service is part of the root canal treatment.
97		83T	Suturing a wound is part of the tooth removal. It is also part of a related surgery.97
97		83U	Re-cement is part of the charge for seating an inlay, onlay, veneer, or crown.
97		83V	A material used to seal a root canal is part of the initial treatment done within 24 months.
97		847	This service is not covered. Denture adjustments or follow up care is not covered if done within 6 months of the initial treatment.
97		84N	A build-up is only a benefit when needed to hold a crown in place.
97		84O	A build-up is part of a build-up with a post.
97		84P	A build-up is part of a build-up with a post.
97		84Q	Benefit for this procedure is limited to one time per day per tooth.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		84R	Benefit for pin retention is limited to one time per day per tooth.
97		84S	Benefit for pin retention is limited to one time per day per tooth.
97		84T	Pins are part of the Build-Up.
97		84U	The removal of a post from this tooth is part of the root canal retreatment.
97		84V	The removal of a post from this tooth is part of the root canal retreatment.
97		84W	A new crown under a partial is part of the benefit for the partial.
97		84X	A new crown under a partial is part of the benefit for the partial.
97		851	This service not covered. Replacement is limited to one time every 24 months. This is part of the initial service.
97		853	Recementation of restorations performed within six months of initial placement is considered part of the initial placement fee.
97		867	A separate, additional payment is not provided for alveoloplasty done in conjunction with the surgical removal of teeth.
97		891	Benefits limited to once per orthodontic case.
97		8A1	This services is not covered. Replacement of crown is not covered if performed within twenty four months of the 1st placement.
97		8A2	Replacement of an amalgam or composite restoration is not covered if performed within twelve months of the initial placement.
97		8A4	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.
97		8A8	A separate, additional payment is not provided for repair or relines done within six months after initial placement of occlusal guard.
97		8A9	Retreatment of root canal or apical surgery performed within 12 months of initial treatment is considered part of the initial treatment fee.
97		8B1	This services is not covered. Replacement of a filling is not covered if performed within twelve months of the initial placement.
97		8B2	This service is not covered. Replacement of a filling is not covered when done within 24 months of the first placement.
97		8E0	A deep cleaning of the entire mouth cannot be done the same day as an exam.
97		8E1	Only one Caries test is covered per day.
97		8E2	This lab made inlay is part of the onlay done on the same day.
97		8E3	Sectioning a fixed partial denture is part of a fixed partial denture.
97		8E4	Emergency treatment to help with mouth pain is part of the treatment.
97		8E5	Emergency treatment to help with mouth pain is part of the treatment.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		8E6	Only one emergency treatment to help with mouth pain is allowed on the same day.
97		8E7	Only one emergency treatment to help with mouth pain is allowed on the same day.
97		900	Benefits limited to once per orthodontic case.
97		905	This predeternination is valid only when the complete denture is placed within 6 months of the extraction(s) in the same arch.
97		917	Retreatment of root canal or apical surgery performed within 6 months of initial treatments is considered part of the initial treatment fee.
97		919	This service is not covered. Denture adjustments or follow up care is not covered if done within 6 months of the initial treatment.
97		921	This service is included in other services on this claim, treatment date or tooth.
97		927	This service is not covered. Based on consultant review, need was not established. Treatment is considered part of the restoration.
97		929	This service is limited. We are allowing this as a different service.
97		930	Based on Consultant review, benefit has been changed.
97		949	A separate, additional payment is not provided for Alveoloplasty in conjunction with surgical removal of teeth.
97		956	A separate additional payment is not provided for reading of Xrays.
97		957	Invisalign is considered cosmetic. Benefit is limited.
97		958	Invisalign is considered cosmetic. Benefit is limited.
97		960	A separate additional payment is not provided for reading of Xrays.
97		969	Post-operative visits are considered a part of the complete procedure. No extra payment is provided.
97		979	Reattachment of a tooth fragment is not covered if done within 24 months of an amalgam or composite restoration or reattachment.
97		993	A separate, additional payment is not provided for denture adjustment and post-op care done within six months after initial placement.
97		994	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.
97		995	Included in orthodontic treatment fee
97		996	Replacement of restoration is not covered if performed withing twenty four months of the initial restoration
97		997	Payment is included in the allowance for another service/procedure.
97		9AS	Full mouth debridement is not to be completed on the same day as an exam.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		9E9	Crown lengthening is included in the fee for the restoration.
97		9F1	Procedure is included in final restoration.
97		9F9	Fees for all x-rays have been given an alternate benefit of a full mouth x-ray.
97		9G1	The fee for this service is included in the fee for the anesthesia.
97		9G2	Retreatment of root canal or apical surgery performed within 12 months of initial treatment is considered part of the initial treatment fee
97		9G6	Benefit Limited Within 6 Months
97		9G9	Retainer adjustments are considered part of the initial treatment fee. Additional benefit is not provided.
97		9H0	Repairs done within 24 months of the initial placement are considered part of the initial restoration fee.
97		9I4	Tissue removal that connects the gums to the lips is part of fixing the bone in the same spot.
97		9I5	Tissue removal that connects the gums to the lips is part of cutting the gums in the same spot.
97		9I6	Tissue removal that connects the gums to the lips is part of the root canal filling.
97		9I7	Tissue removal that connects the gum to the lips is part of the tooth root removal.
97		9I8	A biopsy done at the same time as surgery is part of the surgery.
97		9I9	Replacing pieces of bone is part of a deep cleaning in the same spot within 30 days.
97		9JA	The second stage is part of the initial placement of the implant
97		9JB	The second stage is part of the initial placement of the implant
97		9JC	The second stage is part of the initial placement of the implant
97		9JD	This deep cleaning is part of the Periodontics when done at the same time.
97		9JE	Only one deep cleaning of an implant is allowed on the same day.
97		9JF	Cleaning an implant same day as cleaning the whole mouth is not billable to the patient.
97		9JG	Cleaning an implant is part of a deep cleaning in the same spot within 30 days
97		9JH	Cleaning an implant is part of a deep cleaning in the same spot within 30 days
97		9JI	Cleaning an implant is part of a deep cleaning in the same spot within 30 days
97		9JJ	Cleaning an implant is limited to one time every 2 years.
97		9JK	This is not billable to the patient for 1 year after placing the implant or crown.
97		9JL	Gluing an implant crown back in place is part of seating the implant or crown.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		9JN	For six months after seating the implant or crown, gluing implant crown back on is disallowed.
97		9JO	This is not billable to the patient for 6 months after seating the im plant or crown.
97		9JP	Only one deep cleaning of an implant is allowed on the same day.
97		9JQ	Only one deep cleaning of an implant is allowed on the same day.
97		9JR	A problem focused exam is part of the appointment.
97		9JS	Fixing a sealant is part of the filling.
97		9JT	Tooth care instructions are part of an exam for patients under the age of three.
97		9JU	This type of medicine is part of the restoration.
97		9JV	Removal of tooth root is part of the extraction of the tooth.
97		9JW	A test for the nerve inside of a tooth is part of all treatment on the same day.
97		9JX	This exam is included as part of another exam done on the same day.
97		9JY	This exam is included as part of another exam done on the same day.
97		9JZ	The sealant is part of the filling.
97		9K0	This type of medicine is allowed one time on the same day.
97		9K1	The cleaning of a complete or partial denture is part of all treatment on the same day.
97		9K2	A test of the nerve inside of a tooth is only paid on e time on the same day.
97		9K3	A test for being at risk for cavities is part of the exam for patients under the age of three.
97		9K4	The removal of the root is part of the root surgery.
97		9K5	Pulp removal done within 30 days of a root repair is part of the root repair.
97		9K6	Pulp removal done within 30 days of a root treatment is part of the root treatment.
97		9K7	Removing the pulp from the inside of the tooth is part of the root canal.
97		9L3	The liquid used to help stop cavities is part of the fee for restoring the tooth on the same day.
97		9L5	The dental surgery that shapes the bone is part of the tooth extraction.
97		9L6	Retainers are part of the complete treatment.
97		9L7	This service is part of the gum treatment when done within 30 days.
97		9L8	Retainers are part of the complete treatment.
97		9L9	The exam to see if braces are needed is part of the complete treatment.
97		9M0	Fixing a retainer is part of the complete treatment.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		9M1	Fixing a retainer is part of the complete treatment.
97		9M2	When done on the same day as implant debridement the fee for this service is part of that charge.
97		9M3	The fee for this type exam is included in the fee for the other exam done on the same day.
97		9M4	The fee for this type exam is included in the fee for the other exam done on the same day.
97		9M5	The fee for this service is included in overall patient care.
97		9M6	The fee for this service is included in overall patient care.
97		9M7	The fee for this service is included in the charge for the surgery.
97		9M8	The fee for this service is included in the charge for the surgery.
97		9M9	When done on the same day as implant debridement the fee for this service is part of that charge.
97		9N0	When done on the same day as implant debridement the fee for this service is part of that charge.
97		9N1	This service is part of the follow up care for 90 days.
97		9N2	Fixing a space maintainer is part of gluing in the space maintainer.
97		9N3	Laser treatment is part of the cleaning done on the same day.
97		9N4	Fiberoptic light is part of the exam.
97		9N5	Special material is part of the charge.
97		9N6	This service is part of overall patient care.
97		9N7	Preparing the root is part of a build up or root canal treatment on the same tooth on the same day.
97		9N8	Placing a barrier around the tooth is part of other treatment done on the same tooth on the same day.
97		9N9	When done on the same day as implant debridement the fee for this service is part of that charge.
97		9O0	Taking out a cyst or tumor is part of the other tooth or gum surgery in the same spot.
97		9O1	Adjusting the mouth guard to protect teeth from grinding is part of placing it.
97		9O2	Taking out a space maintainer is part of gluing in the space maintainer.
97		9O3	This cleaning is part of the periodontics when done at the same time.
97		9O4	This service is part of overall patient care.
97		9O5	This material cannot be charged to the patient.
97		9O6	A test for saliva flow within 1 year is part of the first saliva test.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		9O7	Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee.
97		DP3	Allowable benefit has been reduced to the plan allowed amount for this service(s).
97		N01	The charges for this procedure have been considered as part of another more comprehensive procedure code.
97		N02	This procedure is considered redundant to another billed procedure code.
97		N03	This procedure is considered secondary to the primary procedure.
97		N04	This service is considered a part of the original surgical procedure.
97		N05	This service is not covered when performed on the same day as a surgical procedure.
97		N25	The charges for this service have been combined into the primary procedure.
97		N31	The charges for this procedure have been combined with those of the primary procedure.
97		N32	The charges for this procedure have been combined with those of the primary procedure.
97		N50	Current procedure rebundle.
97		N51	History procedure rebundle.
97		N52	Duplicate unilateral or bilateral procedure.
97		N53	Duplicate history unilateral or bilateral procedure.
97		N56	Duplicate procedure submitted.
97		N57	History duplicate procedure submitted.
97		N58	History Mutually Exclusive Procedure
97		N59	History incidental procedure.
97		N65	History post-OP conflict within 90 days.
97		PPC	Exceeds the Ambulatory Payment Classification (APC) rate.
97		SQ1	Patient no longer eligible.
97		WGB	Service is considered included in the payment for another more comprehensive procedure code.
97		WGC	Multiple CPT codes have been combined into one code that describes all the services.
97		WGD	This service or physician visit is considered part of theglobal surgical package. No separate reimbursement is available.
97		WGE	Service is included in the payment for the physician visit code.
97		WGF	Only one visit/evaluation and management code is allowed per date of service.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		WGG	Payment for immunizations includes payment for the injection.
97		WGH	Payment for lab services include blood drawing and/or specimen collection fees.
97		WGI	Procedure code billed more than once for the same day, and appears to be a duplicate billing for the same service.
97		WGL	This procedure code is only eligible to be billed once per day. Additional units for the same day are included.
97		WGM	Service denied because payment already made for the same or similar procedure within the defined time frame.
97		WGN	This procedure code is only eligible to be billed once per week.
97		WGO	This service or supply is included in the payment for another service.
97		WGP	Service is considered a mutually exclusive procedure to another code billed. If required, modifier may not be present/correctly used.
97		WGT	Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.
97		WGt	Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.
97		WGU	NCCI always disallows this procedure when billed with another procedure billed on this DOS. This edit is not eligible for a modifier bypass.
97		WGV	The allowed amount for this lab panel code is adjusted due to amount previously allowed for a panel component.
97		WHA	This service is included in the global obstetic care service and should not be reported separately.
97		WHB	The allowed amount for this global OB code is adjusted due to previously allowed antepartum care.
97		WHF	This service (antepartum, delivery, postpartum, global maternity) may only be billed once per pregnancy. Redundant to another billed code.
97		WHG	Service denied because billed outside of the time-frame requirements for a similar or related servie already allowed.
97		Z07	Not paid to provider when provided to patient in this place of service. Payment included in the reimbursement to the facility.
97		Z08	Not paid to provider when provided to patient in this place of service. Payment included in the reimbursement to the facility.
97		n04	Claim line is disallowed because a surgical code was submitted w/ in the global period w/ a Dx from same category by the same provider

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		n08	History Procedure Code has incidental relationship with this procedure code.
97		n13	History E/M code was billed on a date of service as a minor or procedure without appropriate modifier.
97		n22	Per Medicare, a history procedure code is within the global period of the procedure code on this line
97		n33	Per Medicaid NCCI edits, a history procedure has an unbundle relations hip with the procedure code on this line
97		n34	This claim line is being disallowed because the pre-operative E&M was billed the day before or same day as a surgical procedure.
97		n36	History procedure code is retained from the transfer relationship
97		n37	Claim line is disallowed because a surgical code was submitted w/ in the global period w/ a Dx from same category by the same provider.
97		n39	Claim contains procedure codes that may be bilateral procedures: The documentation for procedures, should be reviewed.
97		n41	This claim line is being disallowed because an E&M code is within the global period by the same provider.
97		n44	This edit occurred because the procedure is identified as a component of another procedure also on the claim for the same service date
97		n45	This claim line is disallowed because a surgical code was submitted w/in the global period w/ a Dx from same category by same provider.
97		n46	This edit occurred because the proc is a component of another proc on the claim coded on the same day, without a qualifying NCCI mod
97		n49	A history claim line is disallowed because more than one anesthesia procedure code was billed on the same DOS.
97		n51	A history claim line is disallowed because its procedure code is unbundled and is considered exclusive.
97		n52	A history claim line is disallowed because its procedure code is unbundled and is considered unbundled.
97		n58	A history claim line is disallowed because its procedure code is unbundled per Medicare.
97		n60	A history line is disallowed because a pre-operative E&M was billed the day before or same day as a surgical procedure in history.
97		n64	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		n65	Service (antepartum, delivery, postpartum, global maternity) may only be billed once per pregnancy. Redundant to another maternity code.
97		n66	This service is included in the global surgical package payment. If required, a modifier was not used or was not supported.
97		n72	Service is included in payment already made for same/similar procedure within set time frame.
97		t05	History Procedure Code has incidental relationship with this procedure code.
97		t11	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97		t14	History E/M code was billed on a date of service as a minor or procedure without appropriate modifier.
97		t15	E/M code billed on a date of service as a minor or major procedure without an appropriate modifier.
97		t25	Procedure Code has an incidental relationship with another procedure code.
97		t29	Medicare: Only intraoperative portion of global payment is allowed.
97		t45	The procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates it is the same condition
97		t56	Per Medicare, a history procedure code is within the global period of the procedure code on this line
97		t60	Per Medicaid NCCI edits, the procedure code has an unbundle relationship with a code in history
97		t63	Per Medicare guidelines, the procedure code has an unbundle relationship with a history procedure code
97		u03	Procedure code not payable with other procedure code reported on the same date.
97		u10	Separately billed services/tests have been bundled as they are consideow reimbursement for surgical assistants on this procedure code.
97		u11	Service (antepartum, delivery, postpartum, global maternity) may only be billed once per pregnancy. Redundant to another maternity code.
97		u23	This service is included in the global surgical package payment. If required, a modifier was not used or was not supported.
97		u31	Service is included in payment already made for the same or similar procedure within the set time frame.
97		u61	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		u62	Service (antepartum, delivery, postpartum, global maternity) may only be billed once per pregnancy. Redundant to another maternity code.
97		u63	This service is included in the global surgical package payment. If required, a modifier was not used or was not supported.
97		u66	A related diagnosis code is missing/incomplete/invalid.
97		u67	Procedure code inconsistent with Place of Service.
97		u69	Service is included in payment already made for same/similar procedure within set time frame.
97		u72	A related diagnosis code is missing/incomplete/invalid.
97		w38	Per Medicaid NCCI edits, a history procedure has an unbundle relationship with the procedure code on this line
97		w39	Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history
97		w45	History procedure code is retained from the transfer relationship
97		w46	History procedure code is retained from the transfer relationship
97		w52	Procedure Code should be denied due to a rebundle into another code
97		w53	History procedure should be denied due to a rebundle into another code
97		w56	Bundled codes transfer into new procedure to be added to this claim
97		w96	Claim contains procedure codes that may be bilateral procedures: The documentation for procedures, should be reviewed.
97		y43	This edit occurred because the procedure is identified as a compo nent of another proc also on the claim for the same service date
97		y44	This edit occurred because the procedure is identified as a component of another procedure also on the claim for the same service date
97		y45	This edit occurred because one or more type T or S procs occur on the same day as a line item containing an E/M code without modifier 25
97		y51	This edit fired because only incidental services are being reported
97		y65	This edit occurred because the proc is a component of another proc on the claim coded on the same day, without a qualifying NCCI mod
97		y66	This edit occurred because the proc is a component of another proc on the claim coded on the same day, without a qualifying NCCI mod
97		y71	This edit occurred because services with service indicator "C" which are on Medicare's 'separate procedures' list
97		y75	This edit is assigned to all other claim lines when one or more claim lines received edit 018

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		z04	This claim line is being disallowed because more than one anesthesia procedure code was billed on the same DOS
97		z05	A history claim line is disallowed because more than one anesthesia procedure code was billed on the same DOS.
97		z14	Documentation is required when a modifier 59 is billed with the procedure code.
97		z20	This claim line is being disallowed because an E&M code is within the global period by the same provider.
97		z21	The procedure code on this claim line is retained from a transfer relationship.
97		z22	Claim line is disallowed because a surgical code was submitted w/ in the global period w/ a Dx from same category by the same provider.
97		z23	A history claim line is disallowed because its procedure code is unbundled and is considered exclusive.
97		z24	A history claim line is disallowed because its procedure code is unbundled.
97		z25	A history claim line is disallowed because its procedure code is disallowed as part of a rebundle relationship.
97		z26	A procedure code on a history claim line was part of a transfer relationship, but the procedure code was retained.
97		z39	This claim line is being disallowed because the procedure code has no Medicare relative value unit and may be considered incidental.
97		z40	Procedure code has no separate payment under physician fee schedule
97		z48	This claim line is being disallowed because the injection service is bundled into other payable services when billed on the same DOS.
97		z54	This claim line is being disallowed because the physical therapy services are not covered by Medicare.
97		z55	This claim line is disallowed because a surgical code was submitted within the global period of a previous surgery by the same provider.
97		z57	A history claim line is disallowed because its procedure code is unbundled per Medicare.
97		z58	This claim line is being disallowed because its procedure code is unbundled per Medicare.
97		z66	This claim line is being disallowed because the pre-operative E&M was billed the day before or same day as a surgical procedure.
97		z67	A history line is disallowed because a pre-operative E&M was billed the day before or same day as a surgical procedure in history.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		z70	This claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship.
97		z75	A transfer to an appropriate procedure occurred. This claim lines procedure was part of the transfer group.
97		z76	This claim line is being disallowed because the procedure code is unbundled and is considered exclusive.
97		z77	This claim line is being disallowed because the procedure code is unbundled.
100	Payment made to patient/insured/responsible party.	None	
	Start: 01/01/1995 | Last Modified: 11/01/2017		
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	None	
101	*Start: 01/01/1995 | Last Modified: 02/28/1999*	909	Treatment plan 1.
101		910	Treatment plan 2.
102	Major Medical Adjustment.	None	
	Start: 01/01/1995	PBM	Major Medical Benefits Applied.
103	Provider promotional discount (i.e. Senior citizen discount).	None	
	Start: 01/01/1995 | Last Modified: 06/30/2001		
104	Managed care withholding.	None	
	Start: 01/01/1995		
105	Tax withholding.	None	
	Start: 01/01/1995		
106	Patient payment option/election not in effect.	None	
	Start: 01/01/1995		
107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
107	*Start: 01/01/1995 | Last Modified: 07/01/2017*	57Q	Add-on code violation. The required primary code for this service has not been billed.
107		5M1	Denied for criteria not met; another specific code (item/service/drug/medication) must also be billed on the same day.
107		71B	Related Procedure Disallow
107		765	Review result. Add-on code violation. The required primary code for this service has not been billed or has been denied in the audit.
107		WGJ	The procedure (add-on) code is not allowed separately. The required primary code was not billed for the same date of service.
107		n10	Primary procedure code on history that is associated with this add-on procedure code received an edit with a deny or review.
107		t02	LCD/ NCD: CMS ID needs additional procedure code
107		t10	Primary procedure code on history that is associated with this add-on procedure code received an edit with a deny or review.
107		u01	A required related procedure code/service is not identified on this claim.
107		w22	Per LCD or NCD guidelines, an additional procedure code is needed to meet policy requirements.
107		w42	The HCPCS add-on code 33225 is lacking a required primary code on the claim.
107		x84	Revenue code 068X and CPT code 99291 not submitted on the same date of service as G0390
107		y59	This edit occurred because a mental health education and/or training services but does not contain any svcs assigned to APC 323,324,or 325
107		y62	This edit occurred because the claim contains an implanted device, but no surgical or other service to implant the device
107		y69	This edit occurred because a blood transfusion or exchange is coded but no blood product is coded
107		y83	This edit occurred because no E/M visit the day of or the day before the observation and the date of observation is not 12/31 or 1/2
107		y84	This edit occurred because code G0379 is present w/o code G0378 for same claim with bill type 13x
107		y99	This edit occurred because blood products are billed with RC 39X and modifier BL without a line billed with RC 38X

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
108	*Start: 01/01/1995 | Last Modified: 07/01/2017*	**89M**	The plan covers rental (not to exceed the reasonable purchase price) of medically necessary durable medical equipment.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	**None**	
109	*Active: 1/1/95 | Last Modified: 01/29/2012*	**054**	Services denied due to being delegated to another entity.
109		**108**	This plan has terminated. Please submit the claim to the new insurance carrier.
109		**40E**	Provider is requested to submit claim to Valueoptions: PO Box 1290, Lathan, NY 12110. For more information call 1-800-892-8804.
109		**450**	Not covered under the dental plan. Service may be eligible for reimbursement under the member's Health Reimbursement Account.
109		**508**	Part D service. Please bill patient.
109		**70G**	Mental Health claims are paid by GOBHI on behalf of EOCCO. Please rebill claim to GOBHI.
109		**70I**	Behavior Health claims are paid by Care Oregon on behalf of OHSU Health IDS. Please rebill claim to Care Oregon
109		**931**	Hospice services need to be billed directly to Original Medicare. Please rebill to the correct carrier.
109		**GOB**	Mental Health claims are paid by GOBHI on behalf of EOCCO. Please Rebill claim to GOBHI
109		**S5**	Member has no coverage for this date of service or benefit type.
109		**y87**	This edit occurred because proc code reported has a status indicator of Y indicating item can only be billed to the DME Regional Carrier
110	Billing date predates service date.	**None**	
	Start: 01/01/1995		
111	Not covered unless the provider accepts assignment.	**None**	
	Start: 01/01/1995		
112	Service not furnished directly to the patient and/or not documented.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
113	*Payment denied because service/procedure was provided outside the United States or as a result of war.*	*None*	
	Start: 01/01/1995 | Last Modified: 02/28/2001 | Stop: 06/30/2007 Replaced by 157, 158 or 159.		
114	Procedure/product not approved by the Food and Drug Administration.	**None**	
	Start: 01/01/1995	**585**	The NDC submitted is not FDA approved for the date of service.
114		**u95**	Date of Service Prior to FDA Approval
115	Procedure postponed, canceled or delayed.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
116	The advance indemnification notice signed by the patient did not comply with requirements.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
117	Transportation is only covered to the closest facility that can provide the necessary care.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
118	ESRD network support adjustment.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
119	Benefit maximum for this time period or occurence has been reached.	**None**	
119	*Start: 01/01/1995 | Last Modified: 02/29/2004*	**062**	All FSA dollars were previously paid out.
119		**13D**	Benefit of one such service per day. Type of service was exhausted on earlier claim for the same date of service.
119		**13M**	Benefit is limited to one time per 12 months.
119		**14M**	Benefit of one such service in 24 consecutive months. Type of service was exhausted on an earlier date of service.
119		**15M**	Benefit of two such services per day. Type of service was exhausted on an earlier claim for the same date of service.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		18D	This service is limited to once per lifetime per tooth space.
119		23M	Benefit of one such service in 3 years.
119		28M	The $50.00 maximum benefit for prenatel/child birthing classes has been met. Patient responsibility applied.
119		45M	Inpatient maximum for this condition has been reached.
119		79M	Maximum benefit has been reached for this type of service.
119		80O	This is not covered. Removable partial Dentures are only covered once in a five year period.
119		80S	Limited to once in a three month period.
119		81B	Limited to Once in a Six Month Period.
119		822	Payment is provided for cast restorations, porcelain crowns, and/or a prosthetic device once in a four year period.
119		824	Payment is provided for a full mouth x-ray (including panographic) once in a two year period.
119		825	Payment is provided for a full mouth x-ray (including panographic) once a year.
119		827	Payment is provided for cast restorations and porcelain crowns once in a three year period.
119		828	Payment is provided for one periodontal recall visit once in a three month period.
119		829	This service is not covered. Benefit for a cast restoration, crown, or prosthetic device is covered one time per five years.
119		82A	Limited to once every two years.
119		82S	Assessments are limited to once in any 12 month period.
119		82Y	A test for hemoglobin is covered once per year.
119		833	Payment is provided for prosthetic appliances once in a five year period.
119		838	Payment is provided for relines, including conditioners, once in a twelve month period.
119		839	Benefit is provided for one rebase in each twelve month period.
119		83W	This service is not covered. Replacement of crown is not covered if performed within two years of the 1st placement.
119		83X	This service is not covered. Replacement of crown is not covered if performed within two years of the 1st placement.
119		83Y	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in an eight year period.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		83Z	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in an eight year period.
119		845	Payment is provided for relines, including conditioners, once in a six month period.
119		84D	Orthodontic service maximum has been met for this benefit period.
119		84Y	Service limited to once in a lifetime when done by the same dentist.
119		852	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a seven year period.
119		854	Payment is provided for cast restorations and porcelain crowns once in any twelve month period.
119		85D	This is not covered. Removable or complete Dentures are only covered once in a ten year period.
119		860	Benefit is provided for topical fluoride once in each six month period.
119		8B3	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a 36 month period.
119		8B4	Limited to once in a five year period.
119		8B5	This service is not covered. Payment for dentures is covered once every 10 years.
119		8B6	Orthodontic records including Models and Photographs are a benefit once in a five year period and limited to a $35.00 maximum.
119		8B7	Benefit is limited to Ten (10) in a Twelve (12) month period.
119		8B8	This is not covered. Removable partial Dentures are only covered once in a five year period.
119		8B9	This is not covered. Replacement of partial Dentures with full dentures are only covered once in a five year period.
119		8C1	Limited to ten services in a three month period.
119		8C2	Limited to once per tooth in five years.
119		8C4	Permanent crowns are limited to four in a seven year period.
119		8C5	Limited to once per tooth per lifetime.
119		8C6	Limited to once in a three year period.
119		8C7	Limited to once every two years.
119		8C8	Limited to once in a six month period.
119		8C9	Limited to once in a ten year period.
119		8D1	Service limited to one time in a lifetime
119		8D2	Limited to once per denture.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		8D3	Limited to once per visit.
119		8D4	Limited to four per year.
119		8D6	Benefit is limited to ten (10) in a three (3) month period.
119		8D8	Limited to once every two years.
119		903	The maximum allowed for this type of service has been reached.
119		90A	A separate payment is not provided when periodontal maintenance is performed within 3 months of periodontal therapy.
119		90C	A separate payment is not provided when periodontal maintenance is performed within 3 months of periodontal therapy.
119		90D	Benefits for Implants are allowed a maximum of 4 per lifetime.
119		925	The maximum allowed for this type of service has been reached.
119		952	Benefit limited to once in a lifetime.
119		953	Benefit is Limited to two (2) times per year.
119		955	Implant maximum has been met for this benefit year.
119		971	Emergency services performed by an out of network provider are limited to a $100.00 maximum benefit.
119		977	Limited to once per tooth in five years.
119		981	Cleaning and inspection of a removable appliance are limited to once per year
119		982	Assessment are limited to 2 in a 12 month period.
119		984	Assessment are limited to once in any 12 month period.
119		9A2	Benefit is 2 prophys per 12 month period. This prophy is the last payment for the benefit period; or, the maximum allowed has been reached.
119		9A3	Benefit is 2 fluoride per 12 month period. This fluoride is the last payment for the benefit period or the maximum allowed has been reached.
119		9A4	The maximum allowed for services of this type has been reached.
119		9A5	The maximum allowed for services of this type has been reached.
119		9B2	Orthodontia services are not covered due to patient's age
119		9B6	Based on review, need was not established. No benefit can be provided.
119		9D0	Complete dentures are covered only one time.
119		9D2	Orthodontic service maximum has been met for this benefit period.
119		9F7	Permanent crowns are limited to four in a seven year period.
119		9F8	Limited to once in a three year period.
119		9H7	No more than two quadrants allowed on the same date of service
119		9K8	Onlay done within 3 months of the liquid used to stop cavities is not covered.
119		9K9	Inlay done within 3 months of the liquid used to stop cavities is not covered.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		9L0	This service when done within 3 months of liquid used to stop cavities is not covered.
119		9L1	Filling done within 3 months of the liquid used to stop cavities is not covered.
119		9L2	Crown done within 3 months of the liquid used to stop cavities is not covered.
119		9L4	The liquid used to help stop cavities is allowed twice per tooth per benefit year.
119		9O8	No more than two quadrants allowed on the same date of service.
119		CG3	Maximum has been met for these services.
119		DP2	The maximum allowed for this type of service has been reached.
119		L09	Class III maximum benefit has been met for this benefit year.
119		L10	Maximum has been met for these services. No further benefits are available.
119		L11	The maximum has been met for durable medical equipment and/or supplies.
119		L13	Preventive health care maximum has been met for this benefit period.
119		L14	Vision service maximum has been met for this benefit period.
119		L15	Chiropractic service maximum has been met for this benefit period.
119		L16	Naturopathic service maximum has been met for this benefit period.
119		L17	Acupuncture service maximum has been met for this benefit period.
119		L18	Alternative care service maximum has been met for this benefit period.
119		L19	Rehabilitation service maximum has been met for this benefit period.
119		L1A	The yearly stoploss has been met. Benefits will be paid at 100% for the remainder of this calendar/plan year.
119		L20	Audio service maximum has been met for this benefit period.
119		L25	Maximum benefit has been met for this benefit year.
119		L26	Orthodontic maximum has been met for this benefit year.
119		L27	TMJ maximum has been met for this benefit year.
119		L28	Periodontal maximum has been met for this benefit year.
119		L40	Infertility service maximum has been met for this benefit period.
119		L41	Hospice Home Respite Maximum has been met.
119		L42	Mental Health service maximum has been met for this benefit period.
119		L43	Chemical Dependency service maximum has been met for this benefit period.
119		L44	Combined Mental Health service maximum has been met for this benefit period.
119		L45	Combined Chemical Dependency service maximum has been met for this benefit period.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		L46	Physical, Speech, Occupational Therapy service maximum has been met for this benefit period.
119		L47	Physical Therapy service maximum has been met for this benefit period.
119		L48	Speech Therapy service maximum has been met for this benefit period.
119		L49	Occupational Therapy service maximum has been met for this benefit period.
119		L50	Family Planning service maximum has been met for this benefit period.
119		L51	Private Duty Nursing service maximum has been met for this benefit period.
119		L52	Medical Prescription service maximum has been met for this benefit period
119		L53	Mental Health and chemical dependency combined counter maximum has been met.
119		L54	Sports Therapy service maximum has been met for this benefit period.
119		L55	Hearing Aid maximum has been met for this benefit period.
119		L56	Hearing exam service maximum has been met for this benefit period.
119		L57	Extended care service maximum has been met for this benefit period.
119		L58	Home health service maximum has been met for this benefit period.
119		L59	Well baby exam maximum has been met for this benefit period.
119		L5A	Prescription self-injectables annual maximum has been met.
119		L5B	Ambulance service maximum has been met for this benefit period.
119		L5D	Skilled nursing facility maximum has been met for this benefit period.
119		L5E	Acupuncture, naturopath and/or licensed massage therapist service maximum has been met for this benefit period.
119		L5F	Well child exam maximum has been met for this benefit period.
119		L60	Individual medical out of pocket maximum has been met.
119		L61	Family medical out of pocket maximum has been met.
119		L62	Individual medical out of network out of pocket maximum has been met.
119		L63	Family medical out of network out of pocket maximum has been met.
119		L64	Individual hospital out of pocket maximum has been met.
119		L65	Family hospital out of pocket maximum has been met.
119		L66	Individual hospital out of network out of pocket maximum has been met.
119		L67	Family hospital out of network out of pocket maximum has been met.
119		L68	Individual medical out of pocket maximum has been met for PCP level.
119		L69	Family medical out of pocket maximum has been met for PCP level.
119		L70	This service limited to one plan per year. Maximum has been met for this benefit period.
119		L72	State mandated hearing aid maximum has been met for this benefit period

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		**PS2**	Exceeds the maximum number of units for this service.
119		**TR5**	Services in excess of benefit maximum.
119		**n69**	Deductible and CoPay apply; preventive benefit used/exhausted this time period.
119		**u92**	Deductible and CoPay apply; preventive benefit used/exhausted this time period.
120	Patient is covered by a managed care plan.	**None**	
	Start: 01/01/1995 | Stop: 06/30/2007 Use code 24		
121	Indemnification adjustment - compensation for outstanding member responsibility.	**None**	
	Start: 01/01/1995 | Last Modified: 09/30/2007		
122	Psychiatric reduction.	**None**	
	Start: 01/01/1995		
123	*Payer refund due to overpayment.*	**None**	
	Active: 1/1/95 Deactivate: 6/30/07		
124	*Payer refund amount - not our patient.*	**None**	
	Active: 1/1/95 Last Modified: 6/30/99 Deactivate: 6/30/07		
125	*Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code)*	**None**	
	Active: 1/1/95 Modified: 6/30/06, 09/30/07 Deactivated: 11/1/2013		
126	*Deductible -- Major Medical*	**None**	
	Active: 2/28/97 Deactivated: 4/1/2008		
127	*Coinsurance -- Major Medical*	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 2/28/97 Deactivated: 4/1/2008		
128	Newborn's services are covered in the mother's Allowance.	None	
	Start: 02/28/1997		
129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	None	
	Start: 02/28/1997 | Last Modified: 01/30/2011		
130	Claim submission fee.	None	
130	*Start: 02/28/1997 | Last Modified: 06/30/2001*	803	A separate fee for completion of a claim form is not covered.
131	Claim specific negotiated discount.	None	
131	*Start: 02/28/1997*	120	The allowance was based on a negotiated rate. The patient is not responsible for the discounted amount.
131		61U	Priced according to OptumHealth Care Solutions contract.
131		73A	Paid according to your PPO contract with CoreChoice
131		7A6	Paid according to your PPO contract with PHS. For contact disputes please call 866.295.0770.
131		7A7	Paid according to your PPO contract with PHS+. For contract disputes please call 866.295.0770.
131		7A8	Paid according to your PPO contract with PHS (IHP). For contract disputes please call 866.295.0770.
131		7A9	Paid according to your PPO contract with PHS (PREVEA). For contract disputes please call 866.295.0770.
131		7B0	Paid according to your PPO contract with PHS (AMCO). For disputes please call 866.295.0770.
131		7B1	Paid according to your PPO contract with PHS (VHN). For contract disputes please call 866.295.0770.
131		7B2	Paid according to your PPO contract with PHS (ACTIVE HC). For contract disputes please call 866.295.0770.
131		7B3	Paid according to your PPO contract with PHS (WRHN). For contract disputes please call 866.295.0770.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		7B4	Paid according to your PPO contract with PHS (NMG). For contract disputes please call 866.295.0770.
131		7B5	Paid according to your PPO contract with PHS (GHCS). For contract disputes please call 866.295.0770.
131		7B6	Paid according to your PPO contract with PHS (LABNET). For contract disputes please call 866.295.0770.
131		7B7	Paid according to your PPO contract with PHS (BELLINHEALTH_&_THEDACARE). For contract disputes please call 866.295.0770.
131		7B8	Paid according to your PPO contract with PHS (EMPOWERCHIRO). For contract disputes please call 866.295.0770.
131		7B9	Paid according to your PPO contract with PHS (CMN). For contract disputes please call 866.295.0770.
131		7C0	Paid according to your PPO contract with PHS-BMI. For disputes please call 866.295.0770.
131		7C1	Paid according to your PPO contract with PHS (VHS-LINK). For contract disputes please call 866.295.0770.
131		7C2	Paid according to your PPO contract with PHS (CCHN). For contract disputes please call 866.295.0770.
131		7C3	Paid according to your PPO contract with PHS (BEHAVIORAL HLTH PROVIDERS) contract. For contract disputes please call 866.295.0770.
131		7C4	Paid according to your PPO contract with PHS (FULCRUM HEALTH). For contract disputes please call 866.295.0770.
131		7C5	Paid according to your PPO contract with PHS (CHIRO MGMT SVCS). For contract disputes please call 866.295.0770.
131		7C6	Paid according to your PPO contract with PHS (YHN). For contract disputes please call 866.295.0770.
131		7C7	Paid according to your PPO contract with PHS (EQUIAN). For contract disputes please call 866.295.0770.
131		80F	Negotiated provider discount has been applied.
131		E60	Paid according to Interlink Health Services contract.
131		E61	Paid according to LifeTrac pricing contract.
131		EDM	Processed with Moda Health contract #111.
131		W01	Paid according to your PPO contract with NPPN/PIPA.
131		W02	Paid according to your PPO contract with NPPN/Family Chiropractic America.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W03	Paid according to your PPO contract with NPPN/Carrington International Group.
131		W04	Paid according to your PPO contract with NPPN/PPOIN.
131		W05	Paid according to your PPO contract with NPPN/OHIO Preferred Network.
131		W06	Paid according to your PPO contract with HealthSmart/HPO
131		W07	Paid according to your PPO contract with NPPN/Beltone.
131		W08	Paid according to your PPO contract with NPPN/Dahlberg Miracle Ear.
131		W09	Paid according to your PPO contract with NPPN/First Choice Healthplan of MS.
131		W10	Paid according to your PPO contract with NPPN/PPOKY.
131		W11	Paid according to your PPO contract with NPPN/CHN/CT.
131		W12	Paid according to your PPO contract with NPPN/HCN - WI/Multiplan.
131		W13	Paid according to your PPO contract with NPPN/First Choice Network.
131		W14	Paid according to your PPO contract with NPPN/Select PPO.
131		W15	Paid according to your PPO contract with NPPN/HCVM.
131		W16	Paid according to your PPO contract with NPPN/AHI/Healthlink.
131		W17	Paid according to your PPO contract with NPPN/Physicians Network.
131		W18	Paid according to your PPO contract with NPPN/Henry Ford Health System.
131		W19	Paid according to your PPO contract with NPPN/FCM.
131		W1A	Paid according to your PPO contract with NPPN/HPO/LTD.
131		W1B	Paid according to your PPO contract with NPPN/HPO/MHN.
131		W1C	Paid according to your PPO contract with NPPN/HPO/MMP.
131		W1D	Paid according to your PPO contract with HealthSmart/HPO
131		W1E	Paid according to your PPO contract with TRPN/ACS.
131		W1F	Paid according to your PPO contract with TRPN/Buckeye Network.
131		W1G	Paid according to your PPO contract with TRPN/CMN.
131		W1H	Paid according to our PPO contract with NPPN (4 Most Health). For contract disputes please call 866.295.770.
131		W1I	Paid according to your PPO contract with TRPN/IMS.
131		W1J	Paid according to your PPO contract with Wellington Health.
131		W1K	Paid according to your PPO contract with American Caresource.
131		W1L	Paid according to your PPO contract with NPPN/TRPN/Primary Health Services.
131		W1M	Paid according to your PPO contract with NPPN/TRPN/PHS/First Choice MS.
131		W1N	Paid according to your PPO contract with NPPN/TRPN/Primaryhlt-Logicomp.
131		W1O	Paid according to your PPO contract with NPPN/TRPN/PHS-Hlthcare-MT States.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W1P	Paid according to your PPO contract with NPPN/TRPN/Primary Hlth Sv-Plus.
131		W1Q	Paid according to your PPO contract with NPPN/TRPN/Primary Hlth-Comp Results.
131		W1R	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Comp Trac.
131		W1S	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Wrk Part.
131		W1T	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Worxs.
131		W1U	Paid according to your PPO contract with NPPN/TRPN/Quality Partnership.
131		W1V	Paid according to your PPO contract with Medical Resource 800.543.5260.
131		W1W	Paid according to your PPO contract with MR/American Care Source
131		W1X	Paid according to your PPO contract with MR/American Health Resources Network.
131		W1Y	Paid according to your PPO contract with MR/California Foundation for Medical Care.
131		W1Z	Paid according to your PPO contract with MR/National Hospital Network.
131		W20	Paid according to your PPO contract with NPPN/ABPA/ProHealth.
131		W21	Paid according to your PPO contract with NPPN/HPO/IHP.
131		W23	Paid according to your PPO contract with NPPN/Intergroup.
131		W24	Paid according to your PPO contract with NPPN/Community Health Partners.
131		W25	Paid according to your PPO contract with NPPN/Association of Primary Care Physicians.
131		W26	Paid according to your PPO contract with NPPN/Columbia HCA North Texas Division.
131		W27	Paid according to your PPO contract with NPPN/Universal/NV.
131		W28	Paid according to your PPO contract with NPPN/TRPN.
131		W29	Paid according to your PPO contract with NPPN/American Care Source.
131		W2A	Paid according to your PPO contract with MR/National Provider Network.
131		W2B	Paid according to your PPO contract with MR/ppoNEXT.
131		W2C	Paid according to your PPO contract with MR/Prime Health Services.
131		W2D	Paid according to your PPO contract with MR/Provider Select Inc.
131		W2E	Paid according to your PPO contract with MR/The Health Payors Organization
131		W2F	Paid according to your PPO contract with NPPN/American PPO
131		W2G	Paid according to your PPO contract with NPPN/Independent Medical System..
131		W2H	Paid according to your PPO contract with NPPN/TRPN/ASPA

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W2I	Paid according to your PPO contract with TRPN/ARAZ
131		W2J	Paid according to your PPO contract with TRPN/CFMC
131		W2K	Paid according to your PPO contract with TRPN/Consumer Health Network
131		W2L	Paid according to your PPO contract with TRPN/Dimension.
131		W2M	Paid according to your PPO contract with TRPN/Family Health America.
131		W2N	Paid according to your PPO contract with TRPN/Fortified Provider Network.
131		W2O	Paid according to your PPO contract with TRPN/HFN.
131		W2P	Paid according to your PPO contract with TRPN/Integrated Health Plan.
131		W2Q	Paid according to your PPO contract with TRPN/Managed Care Strategies.
131		W2R	Paid according to your PPO contract with TRPN/National Provider Network.
131		W2S	Paid according to your PPO contract with TRPN/Ohio Preferred Network.
131		W2T	Paid according to your PPO contract with TRPN/Preferred Mental Health Network.
131		W2U	Paid according to your PPO contract with TRPN/Prime Health Services.
131		W2V	Paid according to your PPO contract with TRPN/Quality Healthcare Partnership.
131		W2W	Paid according to your PPO contract with TRPN/Universal Health Network..
131		W2X	Paid according to your PPO contract with Three Rivers Provider Network (TRPN).
131		W2Y	Paid according to your PPO contract with TRPN/Initial Group.
131		W2Z	Paid according to your PPO contract with TRPN/FCHN.
131		W30	Paid according to your PPO contract with NPPN/Healthcare Network of America.
131		W31	Paid according to your PPO contract with NPPN/PCC PPO.
131		W32	Paid according to your PPO contract with NPPN/MRI.
131		W33	Paid according to your PPO contract with NPPN/MRI/National Hospital Network.
131		W34	Paid according to your PPO contract with NPPN/MRI/National Provider Network.
131		W35	Paid according to your PPO contract with Provider Select (PSI).
131		W36	Paid according to your PPO contract with NPPN/MRI/Galaxy Health Network.
131		W37	Paid according to your PPO contract with NPPN/Health Management.
131		W38	Paid according to your PPO contract with NPPN/Rural Arizona.
131		W39	Paid according to your PPO contract with NPPN/Arizona Medical Network.
131		W3A	Paid according to your PPO contract with NPPN/TRPN/Premium Health.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W3B	Paid according to your PPO contract with TRPN/MCS/ppoNEXT.
131		W3C	Paid according to your PPO contract with Ohio Preferred Network.
131		W3D	Paid according to your PPO contract with Intergroup.
131		W3E	Paid according to your PPO contract with MR/Fortified Provider Network.
131		W3F	Paid according to your PPO contract with MR/HPO/IHP.
131		W3G	Paid according to your PPO contract with MR/HPO/MHN.
131		W3H	Paid according to your PPO contract with MR/HPO/MMPP.
131		W3I	Paid according to your PPO contract with NPPN/Preferred Mental Health Network.
131		W3J	Paid according to your PPO contract with Beech Street Supplemental Network.
131		W3K	Paid according to your PPO contract with NPPN/Medlink Health Network.
131		W3L	Paid according to your PPO contract with NPPN/Fortified Provider Network.
131		W3M	Paid according to your PPO contract with NPPN/MRI/NPN/Premier Care.
131		W3N	Paid according to your PPO contract with NPPN/MRI/NPN/Medical Network of Colorado Springs.
131		W3O	Paid according to your PPO contract with NPPN/Interplan/TX.
131		W3P	Paid according to your PPO contract with NPPN/Baptist Health Services Group.
131		W3Q	Paid according to your PPO contract with NPPN/Lee Physician Hospital Organization.
131		W3R	Paid according to your PPO contract with NPPN/Medical Care Referral Group.
131		W3S	Paid according to your PPO contract with NPPN/MRI/Prime Health Service.
131		W3T	Paid according to your PPO contract with MR/Medical Care Referral Group (MCRG).
131		W3U	Paid according to your PPO contract with Healthsmart HPO/Arizona Medical Network.
131		W3V	Paid according to your PPO contract with Healthsmart HPO/Health Management Network.
131		W3W	Paid according to your PPO contract with Interplan Health Group/ Health Payors Organization.
131		W3X	Paid according to your PPO contract with Healthsmart/HPO.
131		W3Y	Paid according to your PPO contract with HealthSmart HPO/Integrated Health Plan.
131		W3Z	Paid according to your PPO contract with HealthSmart/HPO
131		W40	Paid according to your PPO contract with NPPN/Novanet.
131		W41	Paid according to your PPO contract with NPPN/Mayan PPO.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W42	Paid according to your PPO contract with NPPN/Healthpoint.
131		W43	Paid according to your PPO contract with NPPN/Susquehanna Health Care.
131		W44	Paid according to your PPO contract with BGFH Single source.
131		W45	Paid according to your PPO contract with NPPN/Universal/LA.
131		W46	Paid according to your PPO contract with NPPN/PPONext FKA Preferred Health Network.
131		W47	Paid according to your PPO contract with NPPN/Healthspan.
131		W48	Paid according to your PPO contract with NPPN/Dimension.
131		W49	Paid according to your PPO contract with NPPN/The Initial Group.
131		W4A	Paid according to your PPO contract with Healthsmart HPO/Integrated Health Plan/FPN.
131		W4B	Paid according to your PPO contract with Healthsmart HPO/Integrated Health Plan/NHP.
131		W4C	Paid according to your PPO contract with HPO/Managed Healthcare Northwest.
131		W4D	Paid according to your PPO contract with Healthsmart HPO/Rural Arizona Network.
131		W4E	Paid according to your PPO contract with NPPN/Genesis Physician Group.
131		W4F	Paid according to your PPO contract with Devon Network.
131		W4G	Paid according to your PPO contract with HFN-ID Network.
131		W4H	Paid according to your PPO contract with AMN Network.
131		W4I	Paid according to your PPO contract with NPPN/Rural Arizona.
131		W4J	Paid according to your PPO contract with RAN Network.
131		W4K	Paid according to your PPO contract with HMN Network.
131		W4L	Paid according to your PPO contract with NPPN/Global Health Claim Service Network.
131		W4M	Paid according to your PPO contract with Galaxy/Managed Care Inc.
131		W4N	Paid according to your PPO contract with Plan Care America.
131		W4O	Paid according to your PPO contract with Coalition America.
131		W4P	Paid according to your PPO contract with Integrated Health Plan, Inc.
131		W4Q	Paid according to your PPO contract with IHP/Community Health Alliance.
131		W4R	Paid according to your PPO contract with IHP/FHN Health Network.
131		W4S	Paid according to your PPO contract with IHP/Flora Health Network.
131		W4T	Paid according to your PPO contract with IHP/Fortified Provider Network.
131		W4U	Paid according to your PPO contract with IHP/Galaxy Health Network.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W4V	Paid according to your PPO contract with IHP/Health First Network.
131		W4W	Paid according to your PPO contract with IHP/Health Care Network of America.
131		W4X	Paid according to your PPO contract with IHP/Medical Care Referral Group.
131		W4Y	Paid according to your PPO contract with IHP/Medical Resources.
131		W4Z	Paid according to your PPO contract with IHP/National Hospital Network.
131		W50	Paid according to your PPO contract with NPPN/Dimension/Tenet.
131		W51	Paid according to your PPO contract with NPPN/MH Net.
131		W52	Paid according to your PPO contract with NPPN/Virginia Health Network.
131		W53	Paid according to your PPO contract with NPPN/QualChoice of Arkansas.
131		W54	Paid according to your PPO contract with NPPN/First Choice Health/Sound Health.
131		W55	Paid according to your PPO contract with NPPN/MedicalControl.
131		W56	Paid according to your PPO contract with NPPN/800.557.1656.
131		W57	Paid according to your PPO contract with NPPN/CS-Direct.
131		W58	Paid according to your PPO contract with NPPN/HFN.
131		W59	Paid according to your PPO contract with NPPN/Heartland.
131		W5A	Paid according to your PPO contract with IHP/National Provider Network.
131		W5B	Paid according to your PPO contract with IHP/NPN Indiana Pro Health Network.
131		W5C	Paid according to your PPO contract with IHP/NPN Medical Network of Colorado Springs.
131		W5D	Paid according to your PPO contract with IHP/NPN Premier Care.
131		W5E	Paid according to your PPO contract with IHP/Preferred Care.
131		W5F	Paid according to your PPO contract with IHP/Preferred Care - Aiken SC.
131		W5G	Paid according to your PPO contract with IHP/Prime Health Services Inc.
131		W5H	Paid according to your PPO contract with IHP/ Provider Select Inc.
131		W5I	Paid according to your PPO contract with IHP/ TLC Advantage.
131		W5J	Paid according to your PPO contract with NPPN/Belin Health & Thedacare.
131		W5K	Paid according to your PPO contract with IHP/Medlink.
131		W5L	Paid according to your PPO contract with IHP/PSI/UHN.
131		W5M	Paid according to your PPO contract with IHP/FEDMED.
131		W5N	Paid according to your PPO contract with Provider Select (PSI).
131		W5O	Paid according to your PPO contract with PMCS Networks.
131		W5P	Paid according to your PPO contract with America's PPO.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W5Q	Paid according to your PPO contract with Galaxy PPO.
131		W5R	Paid according to your PPO contract with Fortified Provider Network.
131		W5S	Paid according to your PPO contract with Independent Medical Systems.
131		W5T	Paid according to your PPO contract with IMS/CDA.
131		W5U	Paid according to your PPO contract with IMS/MCS.
131		W5V	Paid according to your PPO contract with PSI/Universal Health.
131		W5W	Paid according to your PPO contract with PSI/Preferred Care.
131		W5X	Paid according to your PPO contract with PSI/JerseyMed.
131		W5Y	Paid according to your PPO contract with PSI/MCRG.
131		W5Z	Paid according to your PPO contract with PPI/IHG/HPO.
131		W60	Paid according to your PPO contract with NPPN/CHN/NJ.
131		W61	Paid according to your PPO contract with Evolutions Healthcare Systems.
131		W62	Paid according to your PPO contract with FIPA/NAMM/PHYCOR Group.
131		W63	Paid according to your PPO contract with EHS/HPO Limited.
131		W64	Paid according to your PPO contract with EHS/Interplan.
131		W65	Paid according to your PPO contract with EHS/Intergroup.
131		W66	Paid according to your PPO contract negotiated agreement.
131		W67	Paid according to your PPO contract with EHS/Managed Care of America.
131		W68	Paid according to your PPO contract with EHS/Galaxy.
131		W69	Paid according to your PPO contract with EHS/Medical Resource.
131		W6A	Paid according to your PPO contract with NovaNet.
131		W6B	Paid according to your PPO Contract with Health Management Associates.
131		W6C	Paid according to your PPO Contract with Ashland Area Alliance PPO.
131		W6D	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6E	Paid according to your PPO Contract with Intergroup.
131		W6F	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6G	Paid according to your PPO Contract with IHG/Healthspan Preferred.
131		W6H	Paid according to your PPO Contract with IHG/HMA/Health Mgmt Ntwk Excl.
131		W6I	Paid according to your PPO Contract with IHG/HPO
131		W6J	Paid according to your PPO Contract with HealthSmart HPO/PHP.
131		W6K	Paid according to your PPO Contract with IHG/NOMS.
131		W6L	Paid according to your PPO Contract with IHG/NorthCoast Health Solutions.
131		W6M	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6N	Paid according to your PPO Contract with IHP/NPNCI Network
131		W6O	Paid according to your PPO Contract with Fed/MED/MPE/IHP.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W6P	Paid according to your PPO Contract with IHP/First Choice.
131		W6Q	Paid according to your PPO Contract with IHP/CoreChoice.
131		W6R	Paid according to your PPO Contract with NHBC
131		W6S	HealthSmart HPO/Health Coalition Partners.
131		W6X	Paid according to your PPO contract with PHCS Healthy Directions Network
131		W6Y	Paid according to your PPO contract with PHCS Network.
131		W6Z	Paid according to your PPO contract with Beech Street Network.
131		W70	Paid according to your PPO contract with EHS/PPONext.
131		W71	Paid according to your PPO contract with Post Acute Care.
131		W72	Paid according to your PPO contract with EHS/TRPN/HPO.
131		W73	Paid according to your PPO contract negotiated agreement.
131		W74	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica.
131		W75	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica (Shared Savings).
131		W76	Paid according to your PPO contract with NCN/Multiplan.
131		W77	Paid according to your PPO contract with NCN/American Care Source (ACS).
131		W78	Paid according to your PPO contract with Concentra/Multiplan.
131		W79	Paid according to your PPO contract with NPPN/Healthcare Direct.
131		W7A	Paid according to your PPO contract with ACPN.
131		W7B	Paid according to your PPO contract with USAMCO.
131		W7C	Paid according to your PPO contract with CCO.
131		W7D	Paid according to your PPO contract with HMNHI.
131		W7G	Paid according to your contract with HRGi.
131		W80	Paid according to your PPO contract with NPPN/InterWest Health.
131		W81	Paid according to your PPO contract with NPPN/America's PPO.
131		W82	Paid according to your PPO Contract with NPPN/Comp Care of the Ozark s (CCO).
131		W83	Paid according to your PPO contract with NPPN/Accountable Health Plans.
131		W84	Paid according to your PPO contract with NPPN/PPOIN/ProHealth.
131		W85	Paid according to your PPO contract with NPPN/PPONext.
131		W86	Paid according to your PPO contract with NPPN/TRPN-FPN.
131		W87	Paid according to your PPO contract with NPPN/TRPN-QHP.
131		W88	Paid according to your PPO contract with PPONext.
131		W89	Paid according to your PPO contract with Mulitplan.
131		W90	Paid according to your PPO contract with NPPN/TRPN/MCS.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W91	Paid according to your PPO contract with NPPN/TRPN/Preferred Mental Health Management.
131		W94	Paid according to your PPO contract with NPPN/HPO/IHP/FPN.
131		W95	Paid according to your PPO contract with NPPN/HPO/IHP/NHP.
131		W96	Paid according to your PPO contract with NPPN/HPO/CHP.
131		W98	Paid according to your PPO contract with NPPN/HPO/HCP.
131		W99	Paid according to your PPO contract with PHCS Healthy Directions Network.
131		WP5	Paid according to your PPO contract with America's PPO.
132	Prearranged demonstration project adjustment.	None	
	Active: 2/28/97		
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	None	
	Start: 07/01/2014 | Last Modified: 07/01/2017	52M	Pending hospital audit.
134	Technical fees removed from charges.	None	
134	*Start: 10/31/1998*	u94	Per the MPFS PC/TC indicator, procedure code describes a physician interpretation for service and a technical component may not be billed.
135	Interim bills cannot be processed.	None	
135	*Start: 10/31/1998 | Last Modified: 09/30/2007*	19M	Benefits cannot be considered until OB care has been completed. Please submit claim at that time.
135		527	Interim bills can not be processed. These services will be processed on final billing. Please submit claim when services completed.
135		70N	Interim Billing Declined. Resubmit claim with total billed charges with In-PT/Residential care is complete.
136	Failure to follow prior payer's coverage rules. (Use Group Code OA)	None	
	Start: 10/31/1998 | Last Modified: 07/01/2013		
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	None	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	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 | Stop: 5/1/2018		
139	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	**None**	
	Active: 6/30/99 | Last Modified: 5/1/2018, 11/1/2017		
140	Patient/Insured health identification number and name do not match.	**None**	
	Start: 06/30/1999		
141	*Claim spans eligible and ineligible periods of coverage.*	**None**	
	Start: 06/30/1999 | Last Modified: 09/30/2007 | Stop: 07/01/2012		
142	Monthly Medicaid patient liability amount.	**None**	
	Start: 06/30/2000 | Last Modified: 09/30/2007		
143	Portion of payment deferred.	**None**	
143	*Start: 02/28/2001*	**57X**	Additional payment to provider once final billing is received.
144	Incentive adjustment, e.g. preferred product/service.	**None**	
144	*Start: 06/30/2001*	**57S**	The allowance on this claim was increased due to MIPS
144		**57V**	The allowance on this claim was increased due to MIPS
145	*Premium payment withholding.*	***None***	
	Start: 06/30/2002 | Last Modified: 09/30/2007 | Stop: 04/01/2008		
146	Diagnosis was invalid for the date(s) of service reported.	**None**	
146	*Start: 06/30/2002 | Last Modified: 09/30/2007*	**792**	One or more diagnosis codes on this claim is not valid for the date(s) of service billed. Please resubmit with valid diagnosis code(s).
146		**793**	One or more diagnosis codes on this claim is not valid for the date(s) of service billed. Please resubmit with valid diagnosis code(s).
146		**u53**	Diagnosis was invalid for the date(s) of service reported.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
146		**w66**	The Other diagnosis code must be valid and is effective based on the through date on the claim.
146		**w86**	Manifestation codes cannot be used as the Admission diagnosis.
147	Provider contracted/negotiated rate expired or not on file.	**None**	
	Start: 06/30/2002		
148	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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
148	*Start: 06/30/2002 | Last Modified: 09/20/2009*	**48O**	Information requested from other provider(s) has not been received.
149	Lifetime benefit maximum has been reached for this service/benefit category.	**None**	
149	*Start: 10/31/2002*	**L12**	TMJ service maximum has been met.
149		**L2B**	Lifetime major medical out of network maximum has been met. No further benefits are available.
149		**L2C**	Chemical dependency lifetime maximum has been met. No further benefits are available.
149		**L2D**	Mental health lifetime maximum has been met
149		**L30**	Dental lifetime maximum has been met.
149		**L31**	Dental lifetime maximum has been met.
149		**L33**	Periodontal lifetime maximum has been met.
149		**L34**	TMJ lifetime maximum has been met.
149		**L35**	Orthodontic lifetime maximum has been met.
149		**L4A**	Diabetes self management lifetime maximum has been met.
149		**L4B**	Bio feedback lifetime maximum has been met.
149		**L6A**	Donor cost lifetime maximum has been met.
149		**L6B**	Pharmacy lifetime maximum has been met.
149		**L8A**	Lifetime maximum for transplantation related expenses has been met.
150	Payer deems the information submitted does not support this level of service.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
150	*Start: 10/31/2002 | Last Modified: 09/30/2007*	71A	DRG submitted is not supported by the claim diagnoses/procedures. DRG reassigned based on claim information.
150		770	Claim review results. DRG has been changed based upon a review of the medical records.
150		775	Billed as Outpatient services; length of stay and/or review doesn't support Outpatient level. Rebill required.
150		776	Review results: Billed as Inpatient services; records review doesn't support Inpatient level. Rebill required. Explanation letter to follow.
150		783	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
150		784	Exceeds the maximum number of units for this service.
150		846	Benefit limited. No history of nonsurgical therapy.
150		89A	Units billed exceed the maximum units allowed per day for this drug/medication. The units over the maximum have been denied.
150		89B	This patient has reached the maximum number of units of this drug/medication for this condition and the claim is denied.
150		89C	Units billed exceed the maximum units allowed per day for this diagnosis combination. The units over the maximum have been denied.
150		8A5	Benefit limited. No history of periodontal treatment.
150		999	Not Covered. No indication of failed reline or clinical stating reline would not be sufficient.
150		9F3	Based on consultant review standard of care not established. No benefit can be provided
150		9F5	Based on consultant review standard of care not established. No benefit can be provided
150		9H2	This is not covered. Chart notes do not provide justification for the treatment
151	Payment adjusted because the payer deems the information submitted does not support this many services/frequency of services.	None	
151	*Start: 10/31/2002 | Last Modified: 01/27/2008*	02D	Unable to predetermine benefits for a buildup under an existing crown. Please submit clinical information when treatment is completed.
151		N11	This procedure is no longer considered clinically effective.
151		N29	Clinical daily maximum exceeded.
151		WGW	The billed units exceed the lifetime maximum for this procedure.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
151		**WGX**	The total billed units for this procedure are medically unlikely.
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
152	*Start: 10/31/2002 | Last Modified: 07/01/2017*	**u18**	
153	Payer deems the information submitted does not support this dosage.	**None**	
	Start: 10/31/2002 | Last Modified: 09/30/2007		
154	Payer deems the information submitted does not support this day's supply.	**None**	
	Start: 10/31/2002 | Last Modified: 09/30/2007		
155	Patient refused the service/procedure.	**None**	
	Start: 06/30/2003 | Last Modified: 09/30/2007		
156	*Flexible spending account payments.*	**None**	
	Start: 09/30/2003 | Last Modified: 01/25/2009 | Stop: 10/01/2009		
157	Service/procedure was provided as a result of an act of war.	**None**	
	Start: 09/30/2003 | Last Modified: 09/30/2007		
158	Service/procedure was provided outside of the United States.	**None**	
	Start: 09/30/2003 | Last Modified: 09/30/2007		
159	Service/procedure was provided as a result of terrorism.	**None**	
	Start: 09/30/2003 | Last Modified: 09/30/2007		
160	Injury/illness was the result of an activity that is a benefit exclusion.	**None**	
	Start: 09/30/2003 | Last Modified: 09/30/2007		
161	Provider performance bonus.	**None**	
	Start: 02/29/2004		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
162	*State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.*	**None**	
	Start: 02/29/2004 | Stop: 07/01/2014 Notes: Use code P1		
163	Attachment/other documentation referenced on the claim was not received.	**None**	
163	*Start: 06/30/2004 | Last Modified: 06/02/2013*	**73Q**	Coordinaton of benefits updated; missing information. Please call customer service.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**None**	
	Start: 06/30/2004 | Last Modified: 06/02/2013		
165	*Referral absent or exceeded.*	**None**	
	Start: 10/31/2004 | Last Modified: 09/30/2007 | Stop 5/1/2018		
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	**None**	
166	*Start: 02/28/2005*	**907**	ODS is a third party administrator for North River Boats. Due to North River Boats' receivership, funds are not available to process claims.
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
167	*Start: 06/30/2005 | Last Modified: 07/01/2017*	**34M**	Treatment for this diagnosis is not covered.
167		**68M**	This service and/or type of treatment is not covered for this diagnosis.
167		**9F4**	Our records indicate the pulp was previously removed from this tooth.
167		**E34**	Treatment for this diagnosis is not covered.
167		**MLN**	Please submit the primary diagnosis.
167		**N19**	This service is not covered when performed for the reported diagnosis.
168	*Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.*	**None**	
	Start: 06/30/2005 | Last Modified: 09/30/2007 | Stop: 5/1/2018		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
169	Alternate benefit has been provided.	**None**	
169	*Start: 06/30/2005 | Last Modified: 09/30/2007*	**70F**	Units combined to apply appropriate member benefit.
169		**80R**	Fees for 3 or 4 bitewing radiographic images have been given an alternate benefit of 2 bitewing images for patients through the age of 9.
169		**80T**	This cleaning code has been converted due to the patient's age.
169		**817**	If a tooth can be restored with a material such as amalgam or composite, payment will be based on the allowable for amalgam or composite.
169		**818**	Tooth colored (composite) fillings on back teeth are not a benefit. Allowance has been made for a silver (amalgam) filling.
169		**823**	Porcelain crowns, if posterior to the upper first molar and the lower second bicuspid are optional. Benefit is for a full gold crown.
169		**840**	An alternative benefit has been provided based on the contract limitation.
169		**842**	Payment is not provided for transitional dentures, treatment dentures, or temporary dentures. Reline benefit is provided.
169		**843**	Overdentures are allowed based on the fee for a standard denture plus an allowance for root canal therapy per overdenture.
169		**892**	Porcelain/resin onlays on posterior teeth are optional. Benefit is provided for a metallic onlay.
169		**81J**	The procedure code has been converted due to the patient's age.
169		**902**	An alternative benefit has been provided based on the contract limitation.
169		**9F2**	Complete and partial overdentures are considered specialized technique. An allowance has been made for a convertional denture.
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
170	*Start: 06/30/2005 | Last Modified: 03/01/2017*	**31M**	This type of provider is not covered.
170		**62M**	The provider is not covered or working in a state approved program.
170		**79N**	Services must be provided through a specialty pharmacy.
170		**79O**	Services must be provided through a specialty pharmacy.
170		**7A5**	The service is not covered. The attending dentist does not participate in ODS/Oregon Health Plan.
170		**928**	Benefits are provided for services, only if performed by an ODS/The Children's Program Participating Dentist.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
170		**98M**	This service is not covered when performed by this type of provider.
170		**u08**	This provider type/provider specialty may not bill this service.
171	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 06/30/2005 | Last Modified: 07/01/2017		
172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 06/30/2005 | Last Modified: 07/01/2017		
173	Service was not prescribed by a physician.	**None**	
173	*Start: 06/30/2005 | Last Modified: 07/01/2013*	**t42**	Per Medicare guidelines, Medicare does not pay for a service or items that do not have a physician order or prescription.
173		**u16**	Not covered when physician order/prescription is missing or invald.
174	Service was not prescribed prior to delivery.	**None**	
	Start: 06/30/2005 | Last Modified: 09/30/2007		
175	Prescription is incomplete.	**None**	
	Start: 06/30/2005 | Last Modified: 09/30/2007		
176	Prescription is not current.	**None**	
	Start: 06/30/2005 | Last Modified: 09/30/2007		
177	Patient has not met the required eligibility requirements.	**None**	
177	*Start: 06/30/2005 | Last Modified: 09/30/2007*	**S13**	The member's coverage was not in effect on the date service was provided.
178	Patient has not met the required spend down requirements.	**None**	
	Start: 06/30/2005 | Last Modified: 09/30/2007		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
179	*Start: 06/30/2005 | Last Modified: 03/01/2017*	36E	No benefits can be paid for services related to this condition/procedure during the exclusionary period.
179		36M	No benefits can be paid for services related to this condition/procedure during the exclusionary period.
179		37E	No benefits can be paid for services related to this condition/procedure during the first six months of coverage.
179		37M	No benefits can be paid for services related to this condition/procedure during the first six months of coverage.
179		908	The date of service is during the waiting period.
179		L5C	Service exclusionary period has not been met.
180	Patient has not met the required residency requirements.	None	
	Start: 06/30/2005 | Last Modified: 09/30/2007		
181	Procedure code was invalid on the date of service.	None	
181	*Start: 06/30/2005 | Last Modified: 09/30/2007*	502	This procedure code is not valid for Medicare. Please resubmit with a valid code for reconsideration of benefits.
181		53B	This procedure code is not accepted for processing by Moda Health for this type of plan and/or line of business.
181		N13	This procedure is not a covered service under your plan.
181		u14	This procedure code is not accepted for processing for this type of plan and/or line of business.
182	Procedure modifier was invalid on the date of service.	None	
182	*Start: 06/30/2005 | Last Modified: 09/30/2007*	u89	Procedure modifier was invalid on the date of service.
182		y46	This edit occurred because the modifier is not in the list of valid OPPS modifiers
182		z34	A modifier on the line is invalid.
183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Start: 06/30/2005 | Last Modified: 07/01/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Start: 06/30/2005 | Last Modified: 03/01/2017		
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Start: 06/30/2005 | Last Modified: 03/01/2017		
186	Level of care change adjustment.	None	
186	*Start: 06/30/2005 | Last Modified: 09/30/2007*	n78	Payment reduction for non-emergency BLS ESRD transport to and from renal dialysis, per CMS guidelines.
186		u75	Payment reduction for non-emergency BLS ESRD transport to and from renal dialysis, per CMS guidelines.
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	None	
	Start: 06/30/2005 | Last Modified: 01/25/2009		
188	This product/procedure is only covered when used according to FDA recommendations.	None	
188	*Start: 06/30/2005*	y93	This edit occurred because the item, service, or procedure was administered or performed prior to the date of FDA approval
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	None	
189	*Start: 06/30/2005*	12E	Claim review results. Not otherwise classified or "unlisted" CPT/HPCS code billed. Specific code available for this procedure/service.
189		710	Not Otherwise classified or "unlisted" code cannot be used. There is a specific procedure code for this procedure/service.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
189		**790**	Not Otherwise classified' or 'unlisted' code cannot be used. There is a specific procedure code for this procedure/services.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	**None**	
	Start: 10/31/2005		
191	*Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)*	*None*	
	Start: 10/31/2005 | Last Modified: 10/17/2010 | Stop: 07/01/2014 *Notes: Use code P2*		
192	Non standard adjustment code from paper remittance. Usage: 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.	**None**	
	Start: 10/31/2005 | Last Modified: 07/01/2017		
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	**None**	
	Active: 2/28/06 | Last Modified: 01/27/2008		
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	**None**	
	Active: 02/28/06 Modified: 09/30/07		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
195	Refund issued to an erroneous priority payer for this claim/service.	**None**	
	Active: 02/28/06 Modified: 09/30/07		
196	*Claim/service denied based on prior payer's coverage determination.*	**None**	
	Start: 06/30/2006 | Stop: 02/01/2007 Use code 136		
197	Precertification/authorization/notification/pre-treatment absent.	**None**	
197	*Start: 10/31/2006 | Last Modified: 5/1/2018, 09/30/2007*	**016**	Reduced Allowable Amount per Unit
197		**018**	Reduced Allowable Units
197		**01M**	Benefit reduced because of non-compliance with cost containment provision of contract
197		**040**	Valid Referral and/or Pre-authorization not obtained.
197		**04M**	This service requires a referral.
197		**134**	No record of pre-authorization from Moda Behavioral on file for this service
197		**135**	No record of pre-authorization on file. No benefits can be allowed.
197		**20M**	This service is not covered. No prior authorization on record.
197		**21M**	This service requires a referral or an authorization.
197		**532**	No prior authorization obtained for this service/item as required by Moda Health Advantage. Do not bill member.
197		**708**	This service is not covered. No prior authorization on record.
197		**81D**	Benefits are payable only when treatment has been pre-determined.
197		**81H**	Services were disallowed by Utilization Management due to no authorization on file at the time services were rendered.
197		**81T**	Units exceed a utilization management authorization.
197		**893**	Predetermination of benefits is required for services performed by a non participating provider.
197		**M21**	This service requires an authorization.
197		**UD**	Amount Disallowed by Utilization Management.
197		**UED**	Utilization Edit Denial.
197		**UM0**	Services were Disallowed by Utilization Management due to no authorization on file at the time services were rendered.
197		**UM1**	Units exceed a utilization management authorization.
197		**UM2**	Units were reduced by a utilization management authorization.
197		**UM3**	Claim matched to a pended UM therefore zero units are allowed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
198	Precertification/notification/authorization/pre-treatment exceeded.	**None**	
198	*Start: 10/31/2006 | Last Modified: 09/30/2007*	**7M0**	Units exceed a utilization management authorization.
199	Revenue code and Procedure code do not match.	**None**	
199	*Start: 10/31/2006*	**80G**	Revenue code and Procedure code do not match. Please rebill with an appropriate revenue code for the services billed.
199		**81C**	Revenue code and Procedure code do not match. Please rebill with an appropriate revenue code for the services billed.
199		**u21**	Revenue Code and Procedure code do not match.
199		**w15**	Whole blood revenue codes can only be used when billing for whole blood.
199		**y70**	This edit occurred because Rev code 762 (observation) is used with a HCPCS code that does not represent an observation svc
199		**y74**	This edit occurred because claim line contains a revenue code for which Medicare requires a HCPCS code
200	Expenses incurred during lapse in coverage.	**None**	
	Start: 10/31/2006		
201	Patient is responsible for amount of this claim/service through "set aside arrangement" or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.	**None**	
	Start: 10/31/2006 | Last Modified: 09/28/2014		
202	Non-covered personal comfort or convenience services.	**None**	
202	*Start: 02/28/2007 | Last Modified: 09/30/2007*	**504**	Personal comfort items are not covered.
203	Discontinued or reduced service.	**None**	
203	*Start: 02/28/2007 | Last Modified: 09/30/2007*	**n70**	Allowable amount for this service/item has been reduced because of a billed modifier.
203		**n84**	Priced per Reduced or Discontinued Service policy; records used if needed.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
203		u46	Discontinued/terminated procedures may not be reported on bilateral services or with units greater than 1, per CMS guidelines.
203		u81	Priced per Reduced or Discontinued Service policy; records used if needed.
203		u96	Allowable amount for this service/item has been reduced because of a billed modifier.
203		w54	The surgical procedure code contains a termination modifier, and all other services on this claim should be denied based on CMS guidelines.
203		w55	The surgical procedure code contains a terminated modifier and should be reviewed for a 50% reduction.
203		y61	This edit occurred because mod 73 is present, an independent or conditional bilateral proc with mod 50 or a proc with units>1
204	The service/equipment/drug is not covered under the patient's current benefit plan.	None	
204	*Start: 02/28/2007*	02M	Classes and other educational/instructional services or materials are not covered.
204		09N	This service/expense is not covered.
204		11M	Non-covered drug/supply.
204		125	State and/or local taxes are not covered.
204		12M	There is no benefit for mailing or handling fees.
204		25M	No coverage for telephone consultation.
204		26M	Charges for missed appointments are not covered.
204		27M	Routine immunization not covered.
204		29M	Medications not requiring a doctor's prescription are excluded by the plan.
204		38M	Charges for reports and/or finance charges are not covered.
204		516	Non-durable medical equipment is not covered.
204		518	No coverage for cosmetic services or supplies.
204		519	This preventive health care service is not covered.
204		521	Maximum benefit has been reached for this type of service.
204		531	Diagnosis on claim not covered by Medicare/ODS Advantage. Claim indicates you were informed of this in writing so you must pay this charge.
204		535	Service/item noncovered by Medicare/ODS Advantage. The provider indicates you were notified of this in advance and you agreed to pay.
204		536	Medicare/ODS Advantage does not cover acupuncture services. Claim indicates you were notified of this in advance and you agreed to pay.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		537	Medicare/ODS Advantage does not cover hearing aids or routine hearing exams. Claim indicates you were notified of this and agreed to pay.
204		538	The provider billed this charge as non-covered and indicates you were notified in advance this was not covered and you agreed to pay.
204		539	Medicare/ODS Advantage does not cover this surgical procedure for obesity. Other procedures are covered when requirements are met.
204		540	This provider is not approved to perform MTM services under this plan. ODS Advantage MTM services are performed by in-house staff only.
204		542	Medicare covers another similar item, but this upgrade model or version is not covered. Claim indicates you were notified and agreed to pay.
204		543	Medicare/ODS Advantage does not cover this method of monitoring your diabetes. Benefits available for blood glucose testing supplies.
204		544	Medicare/ODS Advantage does not cover services, items, or medications to prevent pregnancy.
204		545	Medicare/ODS Advantage does not cover food allergy testing and treatment.
204		546	Medicare/ODS Advantage does not cover transportation in vehicle other than ambulance.
204		547	Medicare/ODS Advantage covers transportation only to the closest facility that can provide the necessary care.
204		548	This item is for use as a compression/surgical dressing and is not covered by Medicare/ODS Advantage.
204		549	Medicare/ODS Advantage covers CPM devices only for the knee and not for this joint or body part.
204		550	Our records show that the date and/or time of death was before the date or time of service.
204		551	Medicare/ODS Advantage does not cover these ancillary (miscellaneous related supplemental) ambulance services/charges.
204		552	Medicare/ODS Advantage does not cover this type of treatment for infertility or services/items to help with becoming pregnant.
204		553	Medicare/ODS Advantage does not pay for online or telephone evaluation and management services such as this.
204		554	Medicare/ODS Advantage does not pay for these services because there was no direct patient treatment and/or contact involved.
204		555	Medicare/ODS Advantage does not cover rehabilitation services for this disease or condition.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		556	Medicare/ODS Advantage does not cover biofeedback for home use or for psychological and/or psychosomatic conditions.
204		557	Medicare/ODS Advantage does not cover this procedure or item because it is considered precautionary or preventive.
204		558	Medicare/ODS Advantage does not cover nutrition, food items, or food supplements if the patient is able to take nutrition orally.
204		559	Non-routine services; not eligible to be covered for routine diagnosis. The claim indicates you were notified of this and agreed to pay.
204		560	These services are not covered because the diagnosis billed is never covered by Original Medicare. Claim indicates you agreed to pay.
204		561	Medicare/ODS Advantage does not cover naturopathic services. Claim indicates you were notified of this in advance and you agreed to pay.
204		562	Medicare covers this service/item only for certain conditions, but not for the diagnosis on this claim. Claim indicates you agreed to pay.
204		564	Medicare/ODS Advantage does not cover this method of bone mass measurement. Another covered test is available and should have been used.
204		565	This vision service is not covered for a routine vision diagnosis by Original Medicare or your ODS Advantage plan.
204		566	The covered portion of this item/service is billed under another code. This portion/upgrade feature is not covered under your plan.
204		567	This is a routine service that does not fall within the list of routine services covered by Original Medicare or your ODS Advantage plan.
204		568	Medicare considers this a personal comfort item and not a covered benefit under Medicate/ODS Advantage. Claim indicates you agreed to pay.
204		569	This item has been forwarded for processing under Part D.
204		570	This medication or item is covered under Medicare Part D. Your ODS Advantage plan does not include Part D coverage.
204		571	The information provided does not support that you meet the criteria to be considered homebound.
204		572	Noncovered. Evidence shows this service does not improve the outcome for the condition it is intended to diagnose or treat.
204		573	The information provided does not support that conventional therapy has been used or has been unsuccessful.
204		574	Medicare/ODS Advantage does not cover biofeedback for the diagnosis listed on this claim. Claim indicates you agreed to pay.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		575	Medicare/ODS Advantage does not cover this service for the diagnosis listed on this claim. Claim indicates you agreed to pay.
204		576	Medicare/ODS Advantage does not cover this surgical procedure for back problems. Other procedures are covered when requirements are met.
204		59M	Your medical plan excludes this type of dental service/supply. If you also have ODS Dental, your claim will be referred to our Dental dept.
204		60M	Provider is requested to submit claim for pricing to: Cofinity, PO Box 2720, Farmington Hills, MI, 48333.
204		61M	The medical plan excludes this type of dental serivce/supply.
204		762	Claim review results. Services determined to be cosmetic upon audit review. Not a covered benefit.
204		763	Claim review results. Services determined to be investigational upon audit review. Not a covered benefit.
204		786	This service/expense is not covered
204		80D	Accident related procedures are not covered under this dental plan.
204		815	No payment is provided for the following fees: periodontal charting, office calls, consultations, or broken appointments.
204		81A	Covered for a pregnant member or member 16 to 20 years old.
204		81E	Braces are only covered to treat cleft palate or Cleft Lip
204		81N	Covered for a pregnant member or member 16 to 20 years old.
204		81O	This service is not covered. Covered only for members under 21.
204		81U	Services to help you stay still are not covered when done with nitrous oxide.
204		81V	Services to help you stay still are not covered when done with nitrous oxide.
204		81W	Services to help you stay still are not covered when done with anesthesia
204		81X	Services to help you stay still are not covered when done with anesthesia
204		826	Payment is not provided for removal of overhangs, re-contouring, discing, polishing teeth, and/or restorations.
204		834	No payment is provided for gnathologic recordings or like procedures.
204		848	Payment is not provided for occlusal guards or like appliance.
204		849	Payment is not provided for procedures or appliances for splinting of teeth.
204		857	Payment is not provided for relative analgesia, pre-medications, sedations and hypnosis for any purpose.
204		858	Payment is not provided for oral medications or prescriptions.
204		861	Payment is not provided for preventive control programs, including plaque control, sealants, etc.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		865	Payment is not provided for hospitalization, including hospital visits and procedures.
204		873	Not a covered benefit.
204		89E	This type of test is not a covered benefit.
204		978	Not covered because you are over age 21 and are not pregnant.
204		9A0	This service is not covered.
204		9A1	The fee charged exceeds the maximum allowance.
204		9A9	This service is not covered.
204		9AO	This service is not covered.
204		9AR	Covered only for members under 21.
204		9B3	Service is covered only for members age 16 through 20.
204		9B4	Benefit is only provided when done on front teeth.
204		9B5	This service is not covered. The fee for this service is considered part of the exam, another service, or follow up care.
204		9C2	Benefit is only provided when done on front teeth.
204		9C3	This service is not covered. Only covered for members 16 to 20 years old.
204		9C4	This service is not covered. A separate payment is not given for temporary treatment or to prepare the tooth.
204		9C5	This type of partial is not a covered benefit.
204		9C7	Temporary dentures are not a covered benefit.
204		9D3	Implant services are not covered.
204		9D4	Bridge services are not covered.
204		9D5	Covered for a pregnant member or member under 21 years old.
204		9D6	Orthodontia only covered to correct cleft palate.
204		9D7	Benefit is only provided when done on back teeth.
204		9D8	This exam is not covered with routine dental visits.
204		9E0	The service is not covered for second molars and wisdom teeth. You are not pregnant or under the age of 21.
204		9F0	The service is not covered for second molars and wisdom teeth. You are not pregnant or under the age of 21.
204		9G3	Crown is not covered on this tooth
204		9G5	Temporary treatment is not covered
204		9J0	This type of Partial is not a covered benefit.
204		E49	Payment is not provided for procedures or appliances for splinting of teeth.
204		N13	This procedure is not a covered service under your plan.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		**y31**	This edit occurred because the procedure code has a non-covered servi ce indicator, meaning that it is non-covered based on Medicare policy
204		**y32**	This edit occurred because the claim was submitted with Cond Code 21 indicating that the provider is requesting verification of denial
204		**y35**	This edit occurred because a procedure code indicates a service N/C by Medicare based on the type of bill and condition codes on the claim
204		**z50**	This claim line is being disallowed because the services are not covered by Medicare.
205	Pharmacy discount card processing fee.	**None**	
	Start: 07/09/2007		
206	National Provider Identifier - missing.	**None**	
	Start: 07/09/2007 | Last Modified: 09/30/2007		
207	National Provider Identifier - Invalid format.	**None**	
	Start: 07/09/2007 | Last Modified: 06/01/2008		
208	National Provider Identifier - Not matched.	**None**	
	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)	**None**	
	Start: 07/09/2007 | Last Modified: 07/01/2013		
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	**None**	
	Start: 07/09/2007		
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	**None**	
	Start: 07/09/2007		
212	Administrative surcharges are not covered.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Start: 11/05/2007		
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	**None**	
	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)*	*None*	
	Start: 01/27/2008 | Last Modified: 10/17/2010 | Stop: 07/01/2014		
215	Based on subrogation of a third party settlement	**None**	
215	*Start: 01/27/2008*	**0M3**	Payment reduction for Subro - Auto.
215		**0M4**	Payment reduction for Subro - Work Comp.
215		**0M5**	Payment reduction for Subro - Other.
215		**70D**	Plan only allow up to the normal benefit less the amount paid by the no-fault, liability or workers' compensation carrier.
216	Based on the findings of a review organization.	**None**	
216	*Start: 01/27/2008*	**589**	Requested by Enrollee or Enrollee's Representative.
217	*Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)*	*None*	
	Start: 01/27/2008 | Last Modified: 09/30/2012 | Stop: 07/01/2014		
218	*Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only*	*None*	
	Start: 01/27/2008 | Last Modified: 09/30/2012 | Stop: 07/01/2014		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
219	Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	**None**	
	Start: 01/27/2008 | Last Modified: 07/01/2017		
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)*	*None*	
	Active: 1/27/08 Modified: 9/30/2012 Deactivated: 7/1/2014		
221	*Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)*	*None*	
	Active: 1/27/08 Modified: 9/30/2012 Deactivated: 7/1/2014		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 06/01/2008 | Last Modified: 07/01/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.	**None**	
	Start: 06/01/2008		
224	Patient identification compromised by identity theft. Identify verification required for processing this and future claims.	**None**	
	Start: 06/01/2008		
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)	**None**	
	Start: 06/01/2008		
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
226	*Start: 09/21/2008 | Last Modified: 07/01/2013*	**42M**	Partial payment only; remainder of charges being held pending receipt of additional information requested from the provider.
226		**48C**	Information requested from the provider has not been received. Benefit has been made for the assessment fee.
226		**48P**	Information requested from the provider(s) regarding pre-existing conditions has not been received.
226		**48R**	Information requested from the provider about medical records necessary to process this claim has not been received.
226		**712**	Records for review & note explaining correction must be attached to corected claims. (FYI - No corrected claims after an audit review.)
226		**758**	Claim review result. No response to records request. Audit will be reopened if records received within 30 days.
226		**769**	Review results. Incomplete response to records request. Audit will be re-opened if missing records/items received within 30 days.
226		**7AT**	The provider is not listed, is missing information on this facility's roster or is not credentialed. Please contact GOBHI to update.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		7AU	The provider is not listed, or is missing information on this facility 's roster. Please contact GOBHI to have them updated.
226		80A	Current panaromic and cephalometric radiographs, intraoral and extraoral photographs, and medical necessity not received from provider.
226		89N	Chart notes showing preparation date and seat date have not been received from the dentist.
226		932	This service is not covered. Chart notes and diagnosis of the treatment has not been received from the dentist to confirm need.
226		933	This service is not covered. Chart notes and PA x-rays have not been received from the dentist to confirm treatment is needed.
226		934	This service is not covered. Report and location of the tissue being removed has not been received from the dentist.
226		935	This service is not covered. Pocket charting and date of last periodontal service (gum treatment) has not been received from the dentist.
226		936	Periodontal charting, periapical x-ray, and diagnosis was not received from the provider to confirm necessity.
226		937	Periodontal charting, periapical x-ray of the abutment teeth and the opposing arch was not received from the provIder to confirm necessity
226		938	Material used was not received from the provider to confirm necessity.
226		939	Pre and post service x-rays were not received from dentist to confirm need.
226		940	Current periapical x-ray not received from the provider to confirm necessity.
226		941	This service is not covered. Chart notes on teeth being replaced and clasped and PA x-ray of abutment teeth not received from the dentist.
226		942	This service is not covered. Panoramic and PA x-rays not received from the dentist to confirm need.
226		943	Chart notes showing if this is the first step of a root canal has not been received from the dentist.
226		944	Chart notes showing if this is the first step of a root canal has not been received from the dentist.
226		945	This service is not covered. Chart notes with missing teeth, teeth being clasped, PA x-ray, and pocket charting not received from dentist.
226		946	This service is not covered. Chart notes showing the final repair and PA x-rays have not been received from the dentist.
226		948	Narrative, current periapical x-ray and photograph was not received from the provider to confirm necessity.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		**Z04**	Additional information requested from provider was not received. Services denied to provider responsibility. Do not bill patient.
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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
227	*Start: 09/21/2008 | Last Modified: 09/20/2009*	**48A**	Information requested from the member about accident details for the conditions on this claim has not been received.
227		**48B**	Information requested from the member about other insurance coverage has not been received.
227		**48D**	Information requested from the member on the accident claim letter has been received, but was incomplete.
227		**48I**	Information requested from the member on the student verification form has been received but was incomplete.
227		**48S**	Information requested from the member on the student verification form has not been received.
227		**48T**	Information requested from the member about third party liability for the conditions on this claim has not been received.
227		**48X**	Information requested from the member regarding pre-existing conditions has not been received.
227		**510**	Requested information not received-Patient.
227		**Z03**	Additional information requested from member was not received. Services denied to member responsibility.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	**None**	
	Start: 09/21/2008		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Usage: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	**None**	
	Start: 01/25/2009 | Last Modified: 07/01/2017		
230	*No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.*	**None**	
	Start: 01/25/2009 Deactivated: 7/1/2014		
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 07/01/2009 | Last Modified: 07/01/2017		
232	Institutional Transfer Amount. Usage - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	**None**	
	Start: 11/01/2009 | Last Modified: 07/01/2017		
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	**None**	
233	*Start: 01/24/2010*	**n61**	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
233		**t53**	A patient reason for visit diagnosis code is required.
233		**u04**	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
233		**u58**	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
	Start: 01/24/2010		
235	Sales Tax	**None**	
	Start: 06/06/2010		
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	**None**	
236	*Start: 01/30/2011 | Last Modified: 07/01/2013*	**u45**	Incorrect coding; bilateral services may not be reported with two lines or two units and anatomic modifiers, per CMS bilateral guidelines.
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
237	*Start: 06/05/2011*	**57T**	The allowance on this claim was decreased due to MIPS.
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	**None**	
	Start: 03/01/2012 | Last Modified: 07/01/2013		
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	**None**	
	Start: 03/01/2012 | Last Modified: 01/29/2012		
240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 06/03/2012 | Last Modified: 07/01/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
241	Low Income Subsidy (LIS) Co-payment Amount	**None**	
	Start: 06/03/2012		
242	Services not provided by network/primary care providers.	**None**	
242	*Start: 06/03/2012 | Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38*	**129**	Use of an in-network provider is required for a higher level of benefits.
242		**132**	Services performed by out-of-network providers are not covered. Refer to the physicians and providers section of the member handbook.
243	Services not authorized by network/primary care providers.	**None**	
	Start: 06/03/2012 | Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38		
244	*Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.*	**None**	
	Start: 9/30/2012 Deactivated: 7/1/2014		
245	Provider performance program withhold.	**None**	
	Start: 09/30/2012		
246	This non-payable code is for required reporting only.	**None**	
246	*Start: 09/30/2012*	**505**	This service is only payable by original Medicare and/or Medicaid. No allowance; for reporting purposes only.
246		**u12**	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	**None**	
	Start: 09/30/2012 Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).		
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Start: 09/30/2012 Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).		
249	This claim has been identified as a readmission. (Use only with Group Code CO)	**None**	
	Start: 09/30/2012		
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT	**None**	
250	*Start: 09/30/2012 | Last Modified: 06/01/2014*	**64M**	Received balance due statement only. Please submit itemized charges from this provider.
250		**73O**	Coordination of benefits updated; unable to verify other carrier information or unknown carrier.
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	**None**	
251	*Start: 09/30/2012 | Last Modified: 06/01/2014*	**73N**	Primary payment estimated; Primary EOB does not match DOS/Service billed.
251		**73R**	Coordination of benefits updated; custody/mandate information needed
251		**73S**	Coordination of benefits updated; due to dependent age/expiration of mandate.
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	**None**	
	Start: 09/30/2012 | Last Modified: 06/01/2014	**113**	For further consideration, the provider needs to submit chart notes for this date of service.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
252		**33L**	Please submit a complete itemization of services, including medical diagnosis, description, and charge for each service.
252		**33M**	Please submit a complete itemization of services, including medical diagnosis, description and charge for each service.
252		**58M**	Please submit medical records for utilization review of pended days.
252		**918**	Please submit an invoice for the provider's purchase of the supply.
252		**970**	Lab pathology report is required.
252		**9F6**	Covered only when submitted with ADA Caries Risk Assessment form.
253	Sequestration - reduction in federal payment	**None**	
	Start: 06/02/2013 | Last Modified: 11/01/2013		
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	**None**	
254	*Start: 06/02/2013*	**06D**	Dental plans are secondary on treatment for accidental injury to the natural teeth. A medical plan's Explanation Of Benefits is required.
254		**70B**	Implants may be covered under Aetna. For details, call 1-855-784-8646 . Once Aetna has reviewed please resubmit the claim with Aetna's EOB.
254		**81F**	This service is not covered by dental. Please submit to your medical carrier.
254		**81Q**	This service is not covered by dental please submit to your medical carrier. . Once Aetna has reviewed please resubmit the claim with Aetna's EOB.
255	*The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		
256	Service not payable per managed care contract.	**None**	
	Start: 06/02/2013		
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	**None**	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Start: 11/01/2013 | Last Modified: 06/01/2014 Notes: To be used after the first month of the grace period.		
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service	**None**	
	Start: 11/01/2013		
259	Additional payment for Dental/Vision service utilization	**None**	
	Start: 01/26/2014		
260	Processed under Medicaid ACA Enhanced Fee Schedule	**None**	
	Start: 01/26/2014		
261	The procedure or service is inconsistent with the patient's history.	**None**	
261	*Start: 06/01/2014*	**n89**	Submitted procedure, service, or modifier is inconsistent with the patient's history.
261		**u20**	Submitted procedure, service, or modifier is inconsistent with the patient's history.
261		**z53**	Submitted procedure, service, or modifier is inconsistent with the patient's history.
262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only	**None**	
	Start: 11/01/2014 | Last Modified: 07/01/2017		
263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only	**None**	
	Start: 11/01/2014 | Last Modified: 07/01/2017		
264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only	**None**	
	Start: 11/01/2014 | Last Modified: 07/01/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	**None**	
	Start: 11/01/2014 | Last Modified: 07/01/2017		
266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	**None**	
	Start: 11/01/2014 | Last Modified: 07/01/2017		
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an Alert.	**None**	
267	*Start: 11/01/2014 | Last Modified: 04/01/2015*	**u30**	Claim/service spans multiple months. Rebill services on separate claims.
267		**u93**	Dates of service span multiple rate periods. Resubmit separate claims.
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	**None**	
	Start: 11/01/2014		
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 03/01/2015 | Last Modified: 07/01/2017		
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration		
	Start: 07/01/2015		
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)		
	Start: 11/01/2015		
272	Coverage/program guidelines were not met.		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
272	*Start: 11/01/2015*	**522**	Not covered because coverage requirements and/or plan/program guidelines were not met.
273	Coverage/program guidelines were exceeded.	**None**	
273	*Start: 11/01/2015*	**N21**	Not covered because Coverage/Program guidelines were exceeded
274	Fee/Service not payable per patient Care Coordination arrangement.	**None**	
	Start: 11/01/2015		
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	**None**	
	Start: 11/01/2015		
276	Services denied by the prior payer(s) are not covered by this payer	**None**	
	Start: 11/01/2015		
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	**None**	
	Start: 11/01/2015		
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 07/01/2016 | Last Modified: 07/1/2017		
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.	**None**	
	Start: 11/1/2016| Last Modified: 7/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	**None**	
	Start: 3/1/2017		
281	Deductible waived per contractual agreement. Use only with Group Code CO.	**None**	
	Start: 7/1/2017		
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
282	*Start: 7/1/2017*	**u07**	The procedure/revenue code is inconsistent with the type of bill.
282		**y79**	This edit occurred because observation "G" codes (G0243, G0244) are billed on a claim with TOB not equal to 13X
282		**y81**	This edit occurred because HCPCS code beginning with the letter C is used with TOB that is not hospital outpt (12X, 13X, 14X)
283	Attending provider is not eligible to provide direction of care.	**None**	
	Start: 11/1/2017		
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	**None**	
	Start: 11/1/2017		
285	Appeal procedures not followed	**None**	
	Start: 11/1/2017		
286	Appeal time limits not met	**None**	
286	*Start: 11/1/2017*	**H38**	Appeal procedures not followed or time limits not met.
286		**H39**	Appeal procedures not followed or time limits not met.
287	Referral exceeded.	**None**	
	Start: 11/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
288	Referral absent	**None**	
288	*Start: 11/1/2017*	**128**	A referral by the Primary Care Physician (PCP) is required for a higher level of benefits.
288		**130**	A referral by the Primary Care Physician (PCP) is necessary to avoid denial of benefits.
288		**740**	This service is not covered. There is no referral from your primary care dentist.
288		**9D9**	This service is not covered. There is no referral from your primary care dentist.
289	Services considered under the dental and medical plans, benefits not available. Notes: Also see CARCs 254, 270 and 280.	**None**	
	Start: 11/1/2017		
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration. Notes: Also see CARCs 254, 270 and 280.	**None**	
	Start: 11/1/2017		
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration	**None**	
	Start: 11/1/2017		
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration	**None**	
	Start: 11/1/2017		
293	Payment made to employer	**None**	
	Start: 5/1/2018		
294	Payment made to attorney.	**None**	
	Start: 11/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
295	Pharmacy Direct/Indirect Remuneration (DIR)	**None**	
	Start: 3/1/2018		
279	Services not provided by Preferred network providers	**None**	
	Start: 11/01/2016		
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	**None**	
	Start: 03/01/2017		
281	Deductible waived per contractual agreement. Use only with Group Code CO.	**None**	
	Start: 7/1/2017		
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Start: 7/1/2017		
283	Attending provider is not eligible to provide direction of care.	**None**	
	Start: 11/1/2017		
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	**None**	
	Start: 11/1/2017		
285	Appeal procedures not followed	**None**	
	Start: 11/1/2017		
286	Appeal time limits not met	**None**	
	Start: 11/1/2017		
287	Referral exceeded.	**None**	
	Start: 11/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
288	Referral absent.	**None**	
	Start: 11/1/2017		
289	Services considered under the dental and medical plans, benefits not available.	**None**	
	Start: 11/1/2017		
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration	**None**	
	Start: 11/1/2017		
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration	**None**	
	Start: 11/1/2017		
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.	**None**	
	Start: 11/1/2017		
293	Payment made to employer	**None**	
	Start: 5/1/2018		
294	Payment made to attorney.	**None**	
	Start: 11/1/2017		
295	Pharmacy Direct/Indirect Remuneration (DIR)	**None**	
	Start: 3/1/2018		
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	**None**	
	Start: 7/1/2018		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
297	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.	**None**	
	Start: 3/1/2019		
298	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's vision plan for further consideration.	**None**	
	Start: 3/1/2019		
299	The billing provider is not eligible to receive payment for the service billed	**None**	
	Start: 7/1/2019		
300	Claim received by the Medical Plan, but benefits not available under this plan. Claim has been forwarded to the patient's Behavioral Health Plan for further consideration	**None**	
	Start: 7/1/2019		
301	Claim received by the Medical Plan, but benefits not available under this plan. Submit these services to the patient's Behavioral Health Plan for further consideration.	**None**	
	Start: 7/1/2019		
A0	Patient refund amount.	**None**	
	Active: 1/1/95	**587**	Member Request for reimbursement.
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.)	**None**	
A1	*Active: 1/1/95 Last Modified: 10/31/06 Eff 6/1/07 At least one Remark Code must be provided.09/20/2009*	**70H**	Claim review result, Hospital Claims Auditor. Item denied or adjust ed. Letter to follow containing further explanation.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
A1		**760**	Claim review results. Item denied or adjusted. Letter follows containing further explanation (if out of network, member is copied).
A1		**766**	Claim review results, Hospital Claims Auditor. Item denied or adjusted. Letter to follow containing further explanation.
A1		**767**	Claim review results. Item denied or adjusted. Letter follow containing further explanation (if out of network, member is copied).
A2	*Contractual adjustment.*	**None**	
	Active: 1/1/95 Last Modified: 2/28/07 Deactivated on 1/1/08		
A4	*Medicare Claim PPS Capital Day Outlier Amount.*	*None*	
	Active: 1/1/95 | Last Modified: 09/30/2007 | Stop: 04/01/2008		
A5	Medicare Claim PPS Capital Cost Outlier Amount.	**None**	
	Active: 1/1/95		
A6	Prior hospitalization or 30 day transfer requirement not met.	**None**	
	Active: 1/1/95		
A7	*Presumptive Payment Adjustment.*	*None*	
	Active: 1/1/95 Deactivated: 7/1/2015		
A8	Ungroupable DRG.	**None**	
	Active: 1/1/95 | Last Modified: 09/30/2007		
B1	Non-covered visits.	**None**	
	Active: 1/1/95		
B4	Late filing penalty.	**None**	
	Active: 1/1/95		
B5	*Coverage/program guidelines were not met or were exceeded.*	***None***	
B5	*Active: 1/1/95 Modified: 2/28/01, 9/30/07*	***522***	*Not covered because coverage requirements and/or plan/program guidelines were not met.*

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
B7	*Active: 1/1/95 Last Modified: 07/1/217, 9/20/09,10/31/98*	70C	DMAP registration required for payment. Go to https://www.modahealth.com/dental/forms.shtml for a DMAP enrollment application.
B7		7A4	DMAP registration required for payment. Go to https://www.modahealth.com/dental/forms.shtml for a DMAP enrollment application.
B7		84M	DMAP registration required for payment. Go to https://www.eocco.com/providers/becomeaprovider for an application
B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	Active: 1/1/95 Modified: 07/1/17, 9/20/09, 9/30/07		
B9	Patient is enrolled in a Hospice.	None	
B9	*Active: 1/1/95 Modified: 9/30/07*	57H	Hospice Related - Please submit to original Medicare for payment.
B9		9B9	Services not covered because the patient is enrolled in 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.	None	
	Active: 1/1/95		
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	None	
	Active: 1/1/95		
B12	Services not documented in patient's medical records.	None	
B12	*Active: 1/1/95| Last modified: 3/1/2018*	756	Claim review results. Service not documented. This is the incorrect code to use for billing the service documented in the medical record.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B12		**757**	Claim review results. Key required elements for this service/item not documented in records received. No separate allowance can be made.
B12		**759**	Review results. Calculation error. The dose or number of items documented in the record does not match the dose or number of units billed.
B12		**768**	Review results. Service not documented. There is no documentation in the submitted medical records to support billing this item or service.
B12		**772**	Claim review results. Service/item not documented. There is no documentation in the medical record to support billing this item or service.
B12		**777**	Review. Incomplete records request response. Documentation for this date of service and/or line item not included in submitted records.
B12		**787**	Please provide proof of loss in the form of a cancelled check or a copy of a bank or credit card statement documenting payment.
B12		**9E1**	Services either not documented or incomplete and insufficient documentation. Requirements not met to support billing this code.
B12		**9E2**	Time not (or not correctly) documented. Code billed based on amount of time performed. Documentation incomplete, services not supported.
B12		**Z05**	Documentation does not support services billed. Denied. Do not bill patient.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**None**	
	Active: 1/1/95	**u90**	
B14	Only one visit or consultation per physician per day is covered.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 9/30/07		
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
B15	*Active: 1/1/95 Modified: 7/1/17, 9/20/09, 9/30/07, 10/31/06*	**N20**	A qualifying service or procedure is required for this service to be covered.
B15		**n07**	Add-on code is also denied when associated primary procedure code is denied.
B15		**n17**	Add-on procedure code has been submitted without appropriate primary procedure.

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B15		**n77**	The procedure (add-on) code cannot be billed by itself. The required primary code was not billed/allowed for the same date of service.
B15		**t04**	Add-on code is also denied when associated primary procedure code is denied.
B15		**t22**	Add-on procedure code has been submitted without appropriate primary procedure.
B15		**t24**	Add-on procedure code has been submitted without an appropriate primary procedure code
B15		**t50**	Modifier GK cannot be submitted alone, another line with GA or GZ must be present on the same claim.
B15		**u44**	The procedure (add-on) code cannot be billed by itself. The required primary code was not billed/allowed for the same date of service.
B15		**u74**	The procedure (add-on) code cannot be billed by itself. The required primary code was not billed/allowed for the same date of service.
B16	New Patient' qualifications were not met.	**None**	
B16	*Active: 1/1/95 Modified: 2/28/01, 9/30/07*	**WGK**	Our records show patient has been treated by this provider/clinic within the past 3 years. Criteria for new patient code has not been met.
B16		**n74**	Our records show patient has been treated by this provider/clinic with in the past 3 years. Criteria for new patient code has not been met.
B16		**u71**	Our records show patient has been treated by this provider/clinic with in the past 3 years. Criteria for new patient code has not been met.
B16		**z61**	This claim line is being disallowed because a new patient E&M service was billed for an established Patient.
B18	*This procedure code/modifier was invalid on the date of service or claim submission.*	**None**	
	Active: 1/1/95 Modified: 9/30/07 | Stop: 03/01/2009		
B20	Procedure/service was partially or fully furnished by another provider.	**None**	
B20	*Active: 1/1/95 Modified: 2/28/01, 9/30/07*	**717**	Our records indicate procedure/service was partially or fully furnished by another provider.
B20		**n19**	The presence of an anesthesia modifier indicates a reduction in payment.
B20		**n63**	Procedure/service was partially or fully furnished by another provider

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B20		n81	Our records indicate procedure/service was partially or fully furnished by another provider.
B20		t26	Medicare: Only intraoperative portion of global payment is allowed.
B20		t27	Medicare: Only postoperative portion of global payment is allowed.
B20		t28	Medicare: Only preoperative portion of global payment is allowed.
B20		t31	The presence of an anesthesia modifier indicates a reduction in payment.
B20		u02	Payment for this service has been issued to another provider.
B20		u41	This claim line is being disallowed because the procedure code has been deleted.
B20		u47	Our records indicate procedure/service was partially or fully furnished by another provider.
B20		u60	Procedure/service was partially or fully furnished by another provider
B20		u78	Our records indicate procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.	None	
B22	*Active: 1/1/95 Last Modified: 2/28/01*	n69	Deductible and CoPay apply; preventive benefit used/exhausted this time period.
B22		u91	Deductible and CoPay waived for this service per Medicare.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	None	
	Active: 1/1/95 Modified: 2/28/01		
D16	*Claim lacks prior payment information.*	None	
	Active: 1/1/95 Deactivated: 6/30/07		
D17	*Claim/Service has invalid non-covered days.*	None	
	Active: 1/1/95 Deactivated: 6/30/07		
D18	*Claim/Service has missing diagnosis information.*	None	
	Active: 1/1/95 Deactivated: 6/30/07		
D19	*Claim/Service lacks Physician/Operative or other supporting documentation.*	None	

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 1/1/95 Deactivated: 6/30/07		
D20	*Claim/Service missing service/product information.*	None	
	Active: 1/1/95 Deactivated: 6/30/07		
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*	None	
	Active: 1/27/08 To Be Deactivated: 1/1/09		
D23	*This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)*	**None**	
	Start: 11/01/2009 | Stop: 01/01/2012		
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P6	Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P8	Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	**None**	
	Start: 11/1/2013		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P12	Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/2017		
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	**None**	
	Start: 11/1/2013		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	**None**	
	Start: 11/1/2013		
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	**None**	
	Start: 11/1/2013		
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only	**None**	
	Start: 11/1/2013| Last modified: 3/1/18, 7/1/17		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P22	Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	**None**	
	Start: 11/1/2013| Last modified: 3/1/18, 7/1/17		
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	**None**	
	Start: 11/1/2013| Last modified: 7/1/17		
W1	*Worker's Compensation State Fee Schedule Adjustment.*	***None***	
	Active: 2/29/00 Modified: 10/17/2010 Deactivated: 7/1/2014		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
W2	*Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.*	**None**	
	Start: 10/17/2010 Deactivated: 7/1/2014		
W3	*The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.*	**None**	
	Start: 9/30/2012 Deactivated: 7/1/2014		
W4	*Workers' Compensation Medical Treatment Guideline Adjustment.*	**None**	
	Start: 9/30/2012 Deactivated: 7/1/2014		
W5	*Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		
W6	*Referral not authorized by attending physician per regulatory requirement.*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		
W7	*Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
W8	*Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		
W9	*Service not paid under jurisdiction allowed outpatient facility fee schedule.*	**None**	
	Start: 6/2/2013 Deactivated: 7/1/2014		
Y1	*Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.*	**None**	
	Start: 9/30/2012 Modified: 6/2/2013 Deactivated: 7/1/2014		
Y2	*Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.*	**None**	
	Start: 9/30/2012 Modified: 6/2/2013 Deactivated: 7/1/2014		

HIPAA CARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
Y3	*Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.*	**None**	
	Start: 9/30/2012 Modified: 6/2/2013 Deactivated: 7/1/2014		