

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
1	Deductible Amount.	None	
1	<i>Active: 1/1/95</i>	006	Reduced Deductible
1		007	Increased Deductible.
1		460	Medicare deductible applied.
1		500	Medicare deductible.
1		D05	Increased dental deductible
1		D06	Decreased dental deductible.
2	Co-insurance Amount.	None	
2	<i>Active: 1/1/95</i>	010	Reduced coinsurance
2		011	Increased coinsurance
2		D09	Increased dental coinsurance
2		D10	Decreased dental coinsurance
2			
3	Co-payment Amount.	None	
3	<i>Active: 1/1/95</i>	004	Reduced copayment
3		005	Increased copayment
3		146	The patient is responsible for this copay for specific services at Monacare Health Clinic.
3		147	Patient is not responsible for these Monacare Health Clinic charges. Disregard patient amounts in this line item--for reporting only.
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		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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
4	<i>Active: 1/1/95   Last Modified 09/20/09</i>	514	The modifier that was billed is invalid for the procedure. Please rebill.
4		N27	The modifier that was billed is invalid for the procedure. Please rebill.

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5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
5	<i>Active: 1/1/95 Last Modified 09/20/09</i>	515	The procedure code and/or bill type is inconsistent with the place of service.
5		N17	The place of service is inconsistent with the procedure that was performed.
5		WGY	The procedure code and/or bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
6	<i>Active: 1/1/95 Last Modified 09/20/09</i>	DP0	The service is not allowed due to the patient's age.
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		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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
7	<i>Active: 1/1/95 Last Modified 09/20/09</i>	ISS	This is not a covered service for this member.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
8	<i>Active: 1/1/95 Last Modified 09/20/09</i>	578	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
9	<i>Active: 1/1/95 Last Modified 09/20/09</i>		

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10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
10	<i>Active: 1/1/95 Last Modified 09/20/09</i>	N14	This service is not covered for this member.
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
11	<i>Active: 1/1/95 Last Modified 09/20/09</i>	46M	The diagnosis is inconsistent with the service billed. Please resubmit with a corrected diagnosis or procedure code.
11		68M	This type of treatment is not covered for this diagnosis.
11		N19	This service is not covered when performed for the reported diagnosis.
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95 Last Modified 09/20/09</i>		
13	The date of death precedes the date of service.	None	
	<i>Active: 1/1/95</i>		
14	The date of birth follows the date of service.	None	
14	<i>Active: 1/1/95</i>	S2	The date of service is before member's date of birth.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 09/30/07</i>		

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16	Claim/service lacks information which is needed for adjudication. 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	
16	<i>Active: 1/1/95 Modified: 6/30/06 Effective 4/1/07 a Remark Code must be provided.</i>	107	The provider is requested to submit a description of this service/supply.
16		110	A signed, valid consent form required. Please submit with claim.
16		112	A valid NDC code is required for physician administered drug covered by the Oregon Health Plan.
16		113	For further consideration, the provider needs to submit chart notes for this date of service.
16		11E	Please resubmit with a valid CPT/HCPCS code.
16		16M	Please resubmit pharmaceutical with valid NDC# and dosage information.
16		33M	Please submit a complete itemization of services, including medical diagnosis, description and charge for each service.
16		48O	Information requested from other provider(s) has not been received.
16		58M	Please submit medical records for utilization review of pended days.
16		60I	Provider is requested to submit claim for pricing to: INTERLINK Health.
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, 6300 Olson Memorial Hwy, Golden Valley MN 55427-4981.
16		64M	Received balance due statement only. Please submit itemized charges from this provider.
16		81M	Partial payment only. The remainder of the claim has been returned for additional information.
16		84M	DMAP provider identification number is required. Please contact Professional Relations for information.
16		85M	Please resubmit with a more specific diagnosis.
16		916	Claim/service lacks information which is needed for adjudication.

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16		918	Please submit an invoice for the supply.
16		920	Clinical information requested to determine benefits. Please submit sufficient clinical evidence of necessity.
16		970	Lab pathology report is required.
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code)	None	
	<i>Active: 1/1/95 Modified: 6/30/06, 9/30/07 Stop: 07/01/2009 Effective 4/1/07 a Remark Code must be provided.</i>		
18	Duplicate claim/service.	None	
18	<i>Active: 1/1/95</i>	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.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	None	
	<i>Active: 1/1/95 Modified: 9/30/07</i>	67M	Work related claims are not covered by your plan. Please submit these charges to your Workers' Compensation carrier.
		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	<i>Active: 1/1/95 Modified: 9/30/07</i>	07M	Please submit this claim to your auto insurance carrier for a determination of their benefits.

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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.
21	This injury/illness is the liability of the no-fault carrier. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
22	This care may be covered by another payer per coordination of benefits. <i>Active: 1/1/95. Modified: 2/28/01, 09/30/07</i>	None	
22		57M	Please send Medicare's explanation of benefits for this claim.
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		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.
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. <i>Active: 1/1/95. Modified: 6/30/05, 09/30/07</i>	None	
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		F7	Charges paid in full by Medicare.
23		781	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
24	Charges are covered under a capitation agreement/managed care plan.	None	

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	<i>Active: 1/1/95. Modified: 6/30/00, 09/30/07</i>	<b>751</b>	Capitation applied.
25	<i>Payment denied. The stoploss deductible has not been met. Active: 1/1/95 Deactivate: 4/1/08</i>	<b>None</b>	
26	Expenses incurred prior to coverage.	<b>None</b>	
26	<i>Active: 1/1/95</i>	<b>S11</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S12</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S14</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S1C</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S20</b>	The date of service is prior to the effective date of coverage.
26		<b>S21</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S22</b>	The member's coverage was not in effect on the date service was provided.
26		<b>S23</b>	The member's coverage was not in effect on the date service was provided.
27	Expenses incurred after coverage terminated.	<b>None</b>	
27	<i>Active: 1/1/95</i>	<b>S10</b>	The member's coverage was not in effect on the date service was provided.
27		<b>S17</b>	The member's coverage was not in effect on the date service was provided.
27		<b>S1D</b>	The member's coverage was not in effect on the date service was provided.
27		<b>S1E</b>	The member's coverage was not in effect on the date service was provided.
27		<b>S1F</b>	The member's coverage was not in effect on the date service was provided.
27		<b>S8</b>	The member's age is beyond the limiting age of the plan.
27		<b>S9</b>	Group no longer eligible.
27		<b>SD1</b>	The member's coverage was not in effect on the date service was provided.
27		<b>SM</b>	Coverage is no longer in force.
27		<b>SM1</b>	The member's coverage was not in effect on the date service was provided.
27		<b>SO</b>	Member no longer eligible. Please check ID card.
27		<b>SQ</b>	The patient is no longer eligible.
27		<b>SS</b>	Member not eligible for benefits.

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27		SW	Member not eligible for benefits.
29	The time limit for filing has expired.	None	
	<i>Active: 1/1/95</i>	TF0	Timely-filing not met. Claim submitted after contract time limit.
30	<i>Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.</i>		
	<i>Active: 1/1/95 Deactivated: 2/1/06. Replaced by 177,178,179 &amp; 180</i>		
31	Patient cannot be identified as our insured.	None	
31	<i>Active: 1/1/95 Modified: 09/30/07</i>	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 your school district.
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		S7	Member is over maximum age.
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 that this dependent is not an eligible dependent as defined.	None	
32	<i>Active: 1/1/95</i>	871	OEA choice trust shows no proof of dependent status.
32		S6	Dependent is over maximum age.
33	Insured has no dependent coverage.	None	
	<i>Active: 1/1/95 Modified: 9/30/07</i>	SC	Member only coverage.
34	Insured has no coverage for newborns.	None	
	<i>Active: 1/1/95 Modified: 09/30/07</i>		

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35	Lifetime benefit maximum has been reached.	None	
35	<i>Active: 1/1/95 Last Modified: 10/31/02</i>	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	
38	<i>Active: 1/1/95 Last Modified: 6/30/03</i>	130	A referral by the Primary Care Physician (PCP) is necessary to avoid denial of benefits.
38		156	A referral by the Primary Care Physician (PCP) is required for a higher level of benefits.
38		704	No benefits are allowable unless services are performed or referred by the primary care dentist.
39	Services denied at the time authorization/pre-certification was requested.	None	
39	<i>Active: 1/1/95</i>	043	This Pre-authorization request was denied.
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
40	<i>Active: 1/1/95   Last Modified: 09/20/2009</i>	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	<i>Charges exceed our fee schedule or maximum allowable amount.</i>	None	
	<i>Active: 1/1/95 Modified: 10/01/06. Deactivated 6/1/07</i>		
43	<i>Gramm-Rudman reduction.</i>		
	<i>Active: 1/1/95 Deactivated: 7/1/06</i>		
44	Prompt-pay discount.	None	

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	<i>Active: 1/1/95</i>		
45	Charges exceed fee schedule / maximum allowable amount or contracted / legislated fee arrangement.	None	
45	<i>Active: 1/1/95. Last Modified: 10/31/06 (Change eff. 6/1/07)</i>	03E	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		2	Increased allowable-provider
45		103	NDC code priced.
45		121	Exceeds authorized length of stay. No medical necessity established for disallowed day(s).
45		133	Negotiated package rates are all-inclusive. Provider is requested to contact the hospital regarding payment.
45		135	No record of pre-authorization on file. No benefits can be allowed.
45		145	PHCS provider discount has been applied.
45		39M	Benefits are provided only for contracted services (CPT Codes). The patient is not responsible for the balance.
45		401	Community Care Network (CCN) provider discount has been applied.
45		502	This procedure code is not valid for Medicare. Please resubmit with a valid code for reconsideration of benefits.
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		513	Service/item noncovered by CMS and ODS Medicare Advantage. ODS requires documentation of prior member notification before billing member.
45		526	Coverage based on Medicare allowed amount.
45		528	Benefits are provided only for contracted services (CPT codes). The patient is not responsible for the balance.

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45		530	Diagnosis on claim not covered by Medicare/ODS Advantage. ODS requires documentation of prior member notification before billing member.
45		532	No prior authorization obtained for this service/item as required by ODS Advantage. Do not bill 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 listed. ODS requires documentation of prior member notification 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		750	This service is not covered. The attending dentist does not participate in the ODS/Oregon Health Plan.
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		D01	Dental allowable-provider.
45		E8M	Provider discount has been applied.
45		GDM	Processed with ODS contract #111.

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45		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		PAA	The charge exceeds the contracted amount for this service.
45		PAC	This is your Per Case 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		PE0	This is your DRG payment.
45		PEO	The charge exceeds the contracted amount for this service.
45		PFC	The charge exceeds the scheduled R & C amount for this procedure.
45		PFX	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		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		PSC	The charge exceeds the usual and customary amount for this procedure.

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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		WGV	The allowed amount for this lab panel code is adjusted due to amount previously allowed for a panel component.
45		WHB	The allowed amount for this global OB code is adjusted due to previously allowed antepartum care.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95   Last Modified: 09/20/2009</i>		
50	These are non-covered services because this is not deemed a "medical necessity" by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
50	<i>Active: 1/1/95   Last Modified: 09/20/2009</i>	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		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		922	Based on consultant review, necessity not established. No benefit can be provided.
50		950	These are non-covered services because this is not deemed a "Medical Necessity" by the payer.
50		N09	The services rendered appear to be cosmetic in nature and not covered under the terms of the plan.

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51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
51	<i>Active: 1/1/95   Last Modified: 09/20/2009</i>	17M	Individual Contestability Exclusion
51		18M	Pre-existing condition not covered for period specified by the plan. The member has not provided credible coverage information.
51		40M	Pre-existing condition not covered for period specified by the plan. The member has not provided credible coverage information.
51		906	Pre-existing conditions are not covered.
52	<i>The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.</i>	None	
	<i>Active: 1/1/95 Deactivated: 2/1/06. Replaced by 170, 183, 184 &amp; 185.</i>		
53	Services by an immediate relative or a member of the same household are not covered.	None	
	<i>Active: 1/1/95</i>		
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
54	<i>Active: 1/1/95   Last Modified: 09/20/2009</i>	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.
55	Procedure/treatment is deemed experimental/investigational by the payer. Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

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55	<i>Active: 1/1/95 Modified: 09/30/07, 09/20/2009</i>	517	Experimental or investigational services and/or supplies are not covered.
55		N10	This procedure is considered experimental in nature and not a covered service under the plan
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95 Modified: 09/30/07, 09/20/2009</i>		
57	<i>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.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07 Split into codes 150, 151, 152, 153 and 154</i>		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 09/30/07, 09/20/2009</i>		
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
59	<i>Active: 1/1/95 Modified: 2/28/07, 09/30/07, 09/20/2009</i>	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		WGQ	Allowance reduced based on Multiple Surgery guidelines.

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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.
60	Charges for outpatient services with this proximity to inpatient services are not covered. <i>Active: 1/1/95</i>	None	
61	This change is to be effective 4/1/2008: penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Active 1/1/95. Modified: 6/30/00, 09/30/07, 09/20/2009</i>	None	
62	<i>Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Active: 1/1/95 Last Modified: 10/31/06 Deactivated: 4/1/07</i>	None	
66	Blood deductible. <i>Active: 1/1/95</i>	None	
69	Day outlier amount. <i>Active: 1/1/95</i>	None	
70	Cost outlier - Adjustment to compensate for additional costs. <i>Active: 1/1/95 Last Modified: 6/30/01</i>	None OUT	Outlier Pricing.
74	Indirect Medical Education Adjustment. <i>Active: 1/1/95</i>	None	
75	Direct Medical Education Adjustment. <i>Active: 1/1/95</i>	None	
76	Disproportionate Share Adjustment. <i>Active: 1/1/95</i>	None	
78	Non-covered days/room charge adjustment. <i>Active: 1/1/95</i>	None 124	Plan allows up to semi-private room rate.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
85	Interest amount. <i>Active: 1/1/95</i>	None	
87	Transfer amount. <i>Active: 1/1/95   Last Modified: 09/20/2009   Stop: 01/01/2012</i>	None	
88	Adjustment amount represents collection against receivable created in prior overpayment. <i>Active: 1/1/95   Deactivated: 6/30/07</i>	None	
89	Professional fees removed from charges. <i>Active: 1/1/95</i>	None	
89		WGZ	This automated lab test is not eligible for separate professional payment.
90	Ingredient cost adjustment. <i>Active: 1/1/95</i>	None	
91	Dispensing fee adjustment. <i>Active: 1/1/95</i>	None	
94	Processed in Excess of charges. <i>Active: 1/1/95</i>	None	
94		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. <i>Active: 1/1/95 Modified: 6/30/00, 09/30/07</i>	None	
95		505	This service is only payable by Original Medicare. No allowance; for reporting purposes only under this member's plan.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
96	<i>Active: 1/1/95 Modified: 6/30/06, 09/20/2009</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		520	Service not covered. The provider has chosen (opted out) or is not allowed (santioned) to bill Mediare 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		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		809	Benefit is provided for fluoride once every six months up through the age of 18.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
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	Our records indicate this tooth was previously extracted.
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		868	Payment is not provided for hospitalization, including hospital visits and procedures.
96		870	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
96		882	Payment is not provided for incomplete treatment. Please file on the completion date.
96		885	Appliances, restorations or procedures are not payable when done to increase vertical dimension.
96		886	Appliances, restorations or procedures are not payable when done to realign teeth.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		887	Appliances, restorations or procedures are not payable when done to treat disturbances of the TMJ and associated structures.
96		890	Appliances, restorations or procedures are not payable when done for cosmetic reasons.
96		924	Appliances, restorations or procedures are not payable when done to correct habits.
96		926	Our records indicate this tooth was previously extracted.
96		A00	Services provided are not a covered benefit with ODS Advantage.
96		DP1	Services on this tooth are not applicable for benefits.
96		E05	Payment is provided only for charges by a licensed dentist.
96		E68	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
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.
97	The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
97	<i>Active: 1/1/95 Modified: 10/31/06, 09/30/07, 09/20/2009</i>	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		505	This service is only payable by original Medicare and/or Medicaid. No allowance; for reporting purposes only.
97		512	This service or supply is included in the payment for another service.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		706	Time documented is less than eight minutes. Service is not separately reimbursable. Does not meet requirements of 8-minute rule.
97		721	The surfaces must be combined and billed, one line per tooth, using appropriate code.
97		77M	Benefits for miscellaneous charges are included in the payment for the base rate.
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	Allowance for this procedure is included in other services on this pre determination, claim and/or the same tooth.
97		807	Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee.
97		819	Preparation of gingival tissue for placing a crown should be included in the fee for the crown.
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		837	Reline is included in the amount of payment provided for the complete replacement of a denture base (jump) fee.
97		847	A separate, additional payment is not provided for denture adjustment and post-op care done within six months after initial placement.
97		851	Replacement of a sealant within 24 months of the initial placement is considered part of the initial fee.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		8A1	Replacement of stainless steel crowns are not covered if performed within twenty four months of the initial 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	Replacement of an amalgam or composite restoration is not covered if performed within twelve months of the initial placement.
97		8B2	Replacement of an amalgam or composite restoration is not covered if performed within twenty four months of the initial placement.
97		900	Benefits limited to once per orthodontic case.
97		919	A separate, additional payment is not provided for denture adjustment and post-op care done within six months after initial placement.
97		921	Allowance for this procedure is included in other services on this predetermination, claim, same day and/or the same tooth.
97		949	A separate, additional payment is not provided for Alveoloplasty in conjunction with surgical removal of teeth.
97		969	Post-operative visits are considered a part of the complete procedure. No extra payment is provided.
97		997	Payment is included in the allowance for another service/procedure.
97		DP3	Allowable benefit has been reduced to the plan allowed amount for this service(s).

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 the primary procedure.
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		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		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	Physician visits are considered part of the surgical procedure or other service/procedure also billed.
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.
97		WGG	Payment for immunizations includes payment for the injection.
97		WGH	Payment for lab services include blood drawing and/or specimen collection fees.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	This procedure code is only eligible to be billed once per month.
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		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		WHA	This service is included in the global obstetric care service and should not be reported separately.
100	Payment made to patient/insured/responsible party.	None	
	<i>Active: 1/1/95</i>		
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	None	
101	<i>Active: 1/1/95 Last Modified: 2/28/99</i>	909	Treatment plan 1.
101		910	Treatment plan 2.
102	Major Medical Adjustment.	None	
	<i>Active: 1/1/95</i>		
103	Provider promotional discount (i.e. Senior citizen discount).	None	
	<i>Active: 1/1/95 Last Modified: 6/30/01</i>		
104	Managed care withholding.	None	
	<i>Active: 1/1/95</i>		
105	Tax withholding.	None	
	<i>Active: 1/1/95</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
<b>106</b>	Patient payment option/election not in effect. <i>Active: 1/1/95</i>	<b>None</b>	
<b>107</b>	The related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>None</b>	
<b>107</b>	<i>Active: 1/1/95</i> <i>Modified: 10/31/06, 09/30/07, 09/20/2009</i>	<b>WGJ</b>	The procedure (add-on) code is not allowed separately. The required primary code was not billed for the same date of service.
<b>108</b>	Payment adjusted because rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	<b>None</b>	
<b>108</b>	<i>Active: 1/1/95 Last Modified: 6/30/02, 09/20/2009</i>	<b>89M</b>	The plan covers rental (not to exceed the reasonable purchase price) of medically necessary durable medical equipment.
<b>109</b>	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	<b>None</b>	
<b>109</b>	<i>Active: 1/1/95</i>	<b>054</b>	Services denied due to being delegated to another entity.
<b>109</b>		<b>108</b>	This plan has terminated. Please submit the claim to the new insurance carrier.
<b>109</b>		<b>40E</b>	Provider is requested to submit claim to Valueoptions: PO Box 1290, Lathan, NY 12110. For more information call 1-800-892-8804.
<b>109</b>		<b>450</b>	Not covered under the dental plan. Service may be eligible for reimbursement under the member's Health Reimbursement Account.
		<b>508</b>	Part D service. Please bill patient.
<b>110</b>	Billing date predates service date. <i>Active: 1/1/95</i>	<b>None</b>	
<b>111</b>	Not covered unless the provider accepts assignment. <i>Active: 1/1/95</i>	<b>None</b>	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
112	Service not furnished directly to the patient and/or not documented. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
113	<i>Payment denied because service/procedure was provided outside the United States or as a result of war.</i> <i>Active: 1/1/95 Deactivated: 6/30/07. Replaced by 157, 158 or 159.</i>	None	
114	Procedure/product not approved by the Food and Drug Administration. <i>Active: 1/1/95</i>	None	
115	Procedure postponed, canceled or delayed. <i>Active: 1/1/95 Modified: 2/28/01, 09/30/07</i>	None	
116	The advance indemnification notice signed by the patient did not comply with requirements. <i>Active: 1/1/95 Modified: 2/28/01, 09/30/07</i>	None	
117	Transportation is only covered to the closest facility that can provide the necessary care. <i>Active: 1/1/95 Modified: 2/28/01, 09/30/07</i>	None	
118	ESRD network support adjustment. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
119	Benefit maximum for this time period has been reached. <i>Active: 1/1/95 Last Modified: 2/29/04</i>	None	
119		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 of one such service in 12 consecutive months.
119		14M	Benefit of one such service in 24 consecutive months. Type of service was exhausted on an earlier date of service.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		15M	Benefit of two such services per day. Type of service was exhausted on an earlier claim for the same date of service.
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 prenatal/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		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	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a five year period.
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		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		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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		85D	Payment is provided for removable complete dentures, removable partial dentures and/or fixed partial dentures once in a 10 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		925	The maximum allowed for services of this type has been reached.
119		9A2	Benefit is 2 prophys per 12 month period. This prophy is the last pay ment 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		9D2	Orthodontic service maximum has been met for this benefit period.
119		CG3	Maximum has been met for these services.
119		DP2	The maximum allowed for this type of service has been reached; or, this service is not covered.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		PS2	Exceeds the maximum number of units for this service.
119		TR5	Services in excess of benefit maximum.
120	Patient is covered by a managed care plan.	None	
	Active: 1/1/95 Deactivate: 6/30/07 Use code 24		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
121	Indemnification adjustment. <i>Active: 1/1/95</i>	None	
122	Psychiatric reduction. <i>Active: 1/1/95</i>	None	
123	Payer refund due to overpayment. <i>Active: 1/1/95 Deactivate: 6/30/07</i>	None	
124	Payer refund amount - not our patient. <i>Active: 1/1/95 Last Modified: 6/30/99 Deactivate: 6/30/07</i>	None	
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) <i>Active: 1/1/95 Modified: 6/30/06, 09/30/07</i>	None	
125		109	Please resubmit with a diagnosis.
125		10M	A signed, valid consent form is required. Please submit with claim.
125		117	Please resubmit with a valid CPT/HCPCS code.
125		511	Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame.
125		577	Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame.
125		5M1	Denied for criteria not met; drug/medication must be billed on the same day.
125		800	A non-ADA or incorrect code has been used. The provider is requested to resubmit a claim with the appropriate ADA CDT code.
125		808	Payment is provided only for charges by a licensed dentist.
125		897	Please resubmit with the appropriate ADA code, clinical information, and reason for placement.
125		923	A non ADA or incorrect code has been used. The provider is requested to re-submit a claim with the appropriate ADA CDT code.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
126	Deductible -- Major Medical <i>Active: 2/28/97</i>	None	
127	Coinsurance -- Major Medical <i>Active: 2/28/97</i>	None	
128	Newborn's services are covered in the mother's Allowance. <i>Active: 2/28/97</i>	None	
129	Prior processing information appears incorrect. This change to be effective 4/1/2011: 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.) <i>Active: 2/28/97</i> <i>Modified: 2/28/01, 09/30/07</i>	None	
130	Claim submission fee. <i>Active: 2/28/97 Last Modified: 6/30/01</i>	None 803	A separate fee for completion of a claim form is not covered.
131	Claim specific negotiated discount.	None	
131	<i>Active: 2/28/97</i>	W01	Paid according to your PPO contract with NPPN/PIPA.
131		W02	Paid according to your PPO contract with NPPN/Family Chiropractic America.
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 NPPN/Interplan.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 NPPN/HPO/PHS.
131		W1E	Paid according to your PPO contract with TRPN/ACS.
131		W1F	Paid according to your PPO contract with NPPN/Buckeye Network.
131		W1G	Paid according to your PPO contract with TRPN/CMN.
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.
131		W1P	Paid according to your PPO contract with NPPN/TRPN/Primary Hlth Sv-Plus.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		W22	Paid according to your PPO contract with NPPN/Baycare.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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
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).

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 NPPN/MRI/Provider Strategies Inc.
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.
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 AP Network.
131		W3K	Paid according to your PPO contract with NPPN/Medlink Health Network.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 HPO/Arizona Medical Network.
131		W3V	Paid according to your PPO contract with HPO/Health Management Network.
131		W3W	Paid according to your PPO contract with Health Payors Organization (HPO)
131		W3X	Paid according to your PPO contract with HPO/Competitive Health Network.
131		W3Y	Paid according to your PPO contract with HPO/Integrated Health Plan.
131		W3Z	Paid according to your PPO contract with Interplan Health Group.
131		W40	Paid according to your PPO contract with NPPN/Novanet.
131		W41	Paid according to your PPO contract with NPPN/Mayan PPO.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 HPO/Integrated Health Plan/FPN.
131		W4B	Paid according to your PPO contract with 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 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 FPN Network.
131		W4J	Paid according to your PPO contract with HMN Network.
131		W4K	Paid according to your PPO contract with RAN 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.
131		W4V	Paid according to your PPO contract with IHP/Health First Network.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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/Direct.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
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		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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 IHG/Ashland Area Alliance PPO.
131		W6D	Paid according to your PPO Contract with IHG/CCH.
131		W6E	Paid according to your PPO Contract with IHG/Guthrie Health Systems.
131		W6F	Paid according to your PPO Contract with IHG/Health Management Associates.
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 IHG/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 IHG/OCN.
131		W6N	Paid according to your PPO Contract with IHP/NPNCI Network
131		W6R	Paid according to your PPO Contract with NHBC
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 Supplemental 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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		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		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 Multiplan.
131		W90	Paid according to your PPO contract with NPPN/TRPN/MCS.
131		W91	Paid according to your PPO contract with NPPN/TRPN/Preferred Mental Health Management.
131		W92	Paid according to your PPO contract with NPPN/TRPN/CFMC.
131		W94	Paid according to your PPO contract with NPPN/HPO/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		W97	Paid according to your PPO contract with NPPN/HPO/CHP/PHA.
131		W98	Paid according to your PPO contract with NPPN/HPO/HCP.
131		W99	Paid according to your PPO contract with NPPN/HPO/LTD.
131		120	The allowance was based on a negotiated rate. The patient is not responsible for the discounted amount.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
132	Prearranged demonstration project adjustment. <i>Active: 2/28/97</i>	None	
133	The disposition of this claim/service is pending further review. <i>Active: 2/28/97 Last Modified: 10/31/99</i>	None 52	Pending hospital audit.
134	Technical fees removed from charges. <i>Active: 10/31/98</i>	None	
135	Interim bills cannot be processed. <i>Active: 10/31/98 Modified: 09/30/07</i>	None 19M 527	Benefits cannot be considered until OB care has been completed. Please submit claim at that time. Interim bills can not be processed. These services will be processed on final billing. Please submit claim when services completed.
136	Failure to follow prior payer's coverage rules. (Use Group Code OA) <i>Active: 10/31/98 Modified: 10/31/06, 09/30/07</i>	None	
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. <i>Active: 2/28/99 Modified: 09/30/07</i>	None	
138	Appeal procedures not followed or time limits not met. <i>Active: 6/30/99 Modified: 09/30/07</i>	H38 H39	Claim/service denied. Appeal procedures not followed or time limits not met. Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services. <i>Active: 6/30/99</i>	None	
140	Patient/Insured health identification number and name do not match. <i>Active: 6/30/99</i>	None	
141	Claim spans eligible and ineligible periods of coverage.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Active: 6/30/99 Modified: 6/30/00, 09/30/07</i>		
<b>142</b>	Monthly Medicaid patient liability amount. <i>Active: 6/30/00 Modified: 09/30/07</i>	<b>None</b>	
<b>143</b>	Portion of payment deferred. <i>Active: 2/28/01</i>	<b>None</b>	
<b>144</b>	Incentive adjustment, e.g. preferred product/service. <i>Active: 6/30/01</i>	<b>None</b>	
<b>145</b>	Premium payment withholding. <i>Active: 6/30/02</i>	<b>None</b>	
<b>146</b>	Diagnosis was invalid for the date(s) of service reported.	<b>None</b>	
<b>146</b>	<i>Active: 6/30/02 Modified: 09/30/07</i>	<b>118</b>	No CPT/HCPCS code billed. According to the UB04 manual, this revenue code requires a CPT/HCPCS code. Please resubmit.
<b>146</b>		<b>992</b>	Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis
<b>147</b>	Provider contracted/negotiated rate expired or not on file. <i>Active: 6/30/02</i>	<b>None</b>	
<b>148</b>	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.) <i>Active: 6/30/02 Modified: 09/30/07, 09/20/2009</i>	<b>None</b>	
<b>149</b>	Lifetime benefit maximum has been reached for this service/benefit category.	<b>None</b>	
<b>149</b>	<i>Active: 10/31/02</i>	<b>L12</b>	TMJ service maximum has been met.
<b>149</b>		<b>L2B</b>	Lifetime major medical out of network maximum has been met. No further benefits are available.
<b>149</b>		<b>L2C</b>	Chemical dependency lifetime maximum has been met. No further benefits are available.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	
150	<i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	846	Benefit limited. No history of nonsurgical therapy.
150		8A5	Benefit limited. No history of periodontal treatment.
151	Payment adjusted because the payer deems the information submitted does not support this many services/frequency of services.	None	
151	<i>Active: 10/31/02. Modified: 09/30/07, 01/27/2008</i>	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.
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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>		
153	Payer deems the information submitted does not support this dosage.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>		
<b>154</b>	Payer deems the information submitted does not support this day's supply.	<b>None</b>	
	<i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>		
<b>155</b>	Patient refused the service/procedure.	<b>None</b>	
	<i>Active: 6/30/03 Modified: 09/30/07</i>		
<b>156</b>	<i>Flexible spending account payments.</i>	<b>None</b>	
	<i>Active: 9/30/03   Last Modified: 01/25/09   Stop: 10/1/2009</i>		
<b>157</b>	Service/procedure was provided as a result of an act of war.	<b>None</b>	
	<i>Active: 9/30/03   Modified: 09/30/07</i>		
<b>158</b>	Service/procedure was provided outside of the United States.	<b>None</b>	
	<i>Active: 9/30/03   Modified: 09/30/07</i>		
<b>159</b>	Service/procedure was provided as a result of terrorism.	<b>None</b>	
	<i>Active: 9/30/03   Modified: 09/30/07</i>		
<b>160</b>	Injury/illness was the result of an activity that is a benefit exclusion.	<b>None</b>	
	<i>Active: 9/30/03 Modified: 09/30/07</i>		
<b>161</b>	Provider performance bonus.	<b>None</b>	
	<i>Active: 2/29/04</i>		
<b>162</b>	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	<b>None</b>	
	<i>Active: 2/29/04</i>		
<b>163</b>	Attachment referenced on the claim was not received.	<b>None</b>	
	<i>Active: 6/30/04 Modified: 09/30/07</i>		
<b>164</b>	Attachment referenced on the claim was not received in a timely fashion.	<b>None</b>	
	<i>Active: 6/30/04 Modified: 09/30/07</i>		
<b>165</b>	Referral absent or exceeded.	<b>None</b>	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Active: 10/31/04 Modified: 09/30/07</i>		
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	None	
166	<i>Active: 2/28/05</i>	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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	None	
167	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>	34M	Treatment for this diagnosis is not covered.
167		E34	Treatment for this diagnosis is not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	None	
	<i>Active: 02/01/06 Modified: 09/30/07</i>		
169	Alternate benefit has been provided.	None	
169	<i>Active: 02/01/06 Modified: 09/30/07</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
169		892	Porcelain/resin onlays on posterior teeth are optional. Benefit is provided for a metallic onlay.
169		902	An alternative benefit has been provided based on the contract limitation.
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	<i>Active: 6/30/05   Last modified: 09/20/2009</i>	31M	This type of provider is not covered.
170		62M	The provider is not covered or working in a state approved program.
170		7A5	The service is not covered. The attending dentist does not participate in ODS/Oregon Health Plan.
170		98M	This service is not covered when performed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>		
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>		
173	Service was not prescribed by a physician.	None	
	<i>Active: 02/01/06 Modified: 09/30/07</i>		
174	Service was not prescribed prior to delivery.	None	
	<i>Active: 02/01/06   Modified: 09/30/07</i>		
175	Prescription is incomplete.	None	
	<i>Active: 02/01/06   Modified: 09/30/07</i>		
176	Prescription is not current.	None	
	<i>Active: 02/01/06   Modified: 09/30/07</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
177	Patient has not met the required eligibility requirements.	None	
177	<i>Active: 02/01/06   Modified: 09/30/07</i>	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	
	<i>Active: 02/01/06   Modified: 09/30/07</i>		
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
179	<i>Active: 02/01/06   Modified: 09/30/07, 09/20/2009</i>	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	
	<i>Active: 02/01/06   Modified: 09/30/07</i>		
181	Procedure code was invalid on the date of service.	None	
181	<i>Active: 02/01/06 Modified: 09/30/07</i>	N13	This procedure is not a covered service under your plan.
182	Procedure modifier was invalid on the date of service.	None	
	<i>Active: 02/01/06. Modified: 8/8/05, 09/30/07</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>		
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>		
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 6/30/05   Last Modified: 09/20/2009</i>		
186	Level of care change adjustment.	None	
	<i>Active: 02/01/06 Modified: 09/30/07</i>		
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	None	
	<i>Active: 6/30/05   Last Modified: 01/25/2009</i>		
188	This product/procedure is only covered when used according to FDA recommendations.	None	
	<i>Active: 6/30/05</i>		
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	<i>Active: 6/30/05</i>	12E	"Not otherwise classified" or "unlisted" CPT/HCPCS code billed. Specific code available for this procedure/service. Please rebill.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
189		710	Not Otherwise classified or "unlisted" code cannot be used. There is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.  <i>Active: 10/31/05</i>	None	
191	Not a work related injury/illness and thus not the liability of the worker's compensation carrier.  <i>Active: 10/31/05 Modified: 09/30/07</i>	None	
192	Non-standard adjustment code from paper remittance. NOTE: 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 reasonable mapped to an existing Claims Adjustment Reason code, specifically Deductible, Coinsurance and Co-payment.  <i>Active: 10/31/05 Modified: 09/30/07</i>	None	
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.  <i>Active: 2/28/06   Last Modified: 01/27/2008</i>	None	
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.  <i>Active: 02/28/06 Modified: 09/30/07</i>	None	
195	Refund issued to an erroneous priority payer for this claim/service.  <i>Active: 02/28/06 Modified: 09/30/07</i>	None	
196	<i>Claim/service denied based on prior payer's coverage determination.</i>  <i>Active: 6/30/06 Deactivated: 2/1/07 Use code 136</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
197	Precertification/authorization/notification absent.	None	
197	<i>Active: 10/31/06   Last Modified: 09/30/07</i>	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 ODS Behavioral on file for this service
197		21M	This service requires a referral or an authorization.
197		81D	Benefits are payable only when treatment has been pre-determined.
197		893	Predetermination of benefits is required for services performed by a non participating provider.
197		9B8	The charge exceeds the amount allowed.
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.
198	Precertification/authorization exceeded	None	
198	<i>Active: 10/31/06   Modified: 09/30/07</i>	95	Level of service billed does not match level of service authorized.
199	Revenue code and Procedure code do not match.	None	
	<i>Active: 10/31/06</i>		
200	Expenses incurred during lapse in coverage.	None	
	<i>Active: 10/31/06</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
201	Workers Compensation case settle. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR).	None	
	<i>Active: 10/31/06</i>		
202	Non-covered personal comfort or convenience services.	None	
202	<i>Active: 2/28/07 Modified: 9/30/07</i>	504	Personal comfort items are not covered.
203	Discontinued or reduced service.	None	
	<i>Active: 2/28/07 Modified: 9/30/07</i>		
204	The service/equipment/drug is not covered under the patient's current benefit plan.	None	
204	<i>Active: 2/28/07</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		536	Medicare/ODS Advantage does not cover acupuncture services. Claim indicates you were notified of this in advance and you agreed to pay.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 Medicare/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	Medicare/ODS Advantage does not cover biofeedback for home use under any circumstances.
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.
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		61M	The medical plan excludes this type of dental service/supply.
204		80D	Accident related procedures are not covered under this dental plan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		815	No payment is provided for the following fees: periodontal charting, office calls, consultations, or broken appointments.
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.
204		873	Not a covered benefit.
204		9A0	This service is not covered.
204		9A9	This service is not covered.
204		E49	Payment is not provided for procedures or appliances for splinting of teeth.
205	Pharmacy discount card processing fee. <i>Active: 7/9/07</i>	None	
206	National Provider Identifier - missing. <i>Active: 7/9/07 Modified: 9/30/07</i>	None	
207	National Provider Identifier - Invalid format. <i>Active: 7/9/07 Modified: 9/30/07 Deactivate: 05/23/08</i>	None	
208	National Provider Identifier - Not matched. <i>Active: 7/9/07 Modified: 9/30/07</i>	None	
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) <i>Active: 7/9/007</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	None	
	<i>Active: 7/9/07</i>		
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	None	
	<i>Active: 7/9/07</i>		
212	Administrative surcharges are not covered.	None	
	<i>Active: 11/05/07</i>		
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	None	
	<i>Active: 1/27/08</i>		
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	
	<i>Active: 1/27/08</i>		
215	Based on subrogation of a third party settlement	None	
215	<i>Active: 1/27/08</i>	0M3	Payment reduction for Subro - Auto.
215		0M4	Payment reduction for Subro - Work Comp.
215		0M5	Payment reduction for Subro - Other.
216	Based on the findings of a review organization.	None	
	<i>Active: 1/27/08</i>		
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	
	<i>Active: 1/27/08</i>		
218	Based on entitlement to benefits. (Note: To be used for Workers' Compensation only)	None	
	<i>Active: 1/27/08</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
219	Based on extent of injury. (Note: To be used for Workers' Compensation only)	None	
	<i>Active: 1/27/08</i>		
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	
	<i>Active: 1/27/08</i>		
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	None	
	<i>Active: 1/27/08</i>		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
	<i>Active: 6/1/08   Last Modified: 09/20/2009</i>		
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.		
	<i>Active: 6/1/08</i>		
224	Patient identification compromised by identity theft. Identify verification required for processing this and future claims.		
	<i>Active: 6/1/08</i>		
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)		
	<i>Active: 6/1/08</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226	Information requested from the Billing/Rendering 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.)		
226	<i>Start: 09/21/2008   Last Modified: 09/20/2009</i>	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		932	Narrative, chart notes and diagnosis of the treatment was not received from the provider to confirm necessity.
226		933	Narrative, current periapical x-ray and diagnosis of the treatment was not received from the provider to confirm necessity.
226		934	Pathology report, narrative and location of the tissue being removed was not received from the provider to confirm necessity.
226		935	Periodontal charting, narrative, diagnosis and date of last periodontal therapy was not received from the provider.
226		936	Periodontal charting, periapical x-ray, narrative 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	Narrative including the material used was not received from the provider to confirm necessity.
226		939	Narrative and pre and post operative periapical x-rays not received from the provider to confirm necessity.
226		940	Narrative and current periapical x-rays not received from the provider to confirm necessity.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		941	Narrative showing teeth being replaced and clasped and periapical x-rays of abutment of teeth not received from provider.
226		942	Narrative, current panoramic and periapical x-rays not received from the provider to confirm necessity.
226		943	Narrative including if the apexification recalcification is the first step of root canal not received from the provider.
226		944	Narrative explaining why this tooth is not restorable was not received from the provider to confirm necessity.
226		945	Narrative including missing teeth and teeth to be clasped, periapical x-ray, and periodontal charting not received from the provider.
226		946	Narrative including final restoration and periapical xray not received from the provider to confirm necessity.
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	<i>Start: 09/21/2008   Last Modified: 09/20/2009</i>	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 about third party liability for the conditions on this claim 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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
227		48X	Information requested from the member regarding pre-existing conditions has not been received.
227		510	Requested information not received-Patient.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication <i>Start: 09/21/2008</i>	None	
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: 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 Group Code PR. <i>Start: 01/25/2009</i>		
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty. <i>Start: 01/25/2009</i>		
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 07/01/2009   Last Modified: 09/20/2009</i>		
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions. <i>Start: 11/01/2009</i>		
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error. <i>Start: 01/24/2010</i>		

HIPAA ARC 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.)		
	<i>Start: 01/24/2010</i>		
235	Sales Tax		
	<i>Start: 06/06/2010</i>		
A0	Patient refund amount.	None	
	<i>Active: 1/1/95</i>		
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	
	<i>Active: 1/1/95 Last Modified: 10/31/06 Eff 6/1/07 At least one Remark Code must be provided.09/20/2009</i>	03E	
A2	Contractual adjustment.	None	
	<i>Active: 1/1/95 Last Modified: 2/28/07 Deactivated on 1/1/08</i>		
A4	Medicare Claim PPS Capital Day Outlier Amount.	None	
	<i>Active: 1/1/95   Last Modified: 09/30/2007   Stop: 04/01/2008</i>		
A5	Medicare Claim PPS Capital Cost Outlier Amount.	None	
	<i>Active: 1/1/95</i>		
A6	Prior hospitalization or 30 day transfer requirement not met.	None	
	<i>Active: 1/1/95</i>		
A7	Presumptive Payment Adjustment.	None	
	<i>Active: 1/1/95</i>		
A8	Ungroupable DRG.	None	
	<i>Active: 1/1/95   Last Modified: 09/30/2007</i>		
B1	Non-covered visits.	None	
	<i>Active: 1/1/95</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
<b>B4</b>	Late filing penalty. <i>Active: 1/1/95</i>	None	
<b>B5</b>	Coverage/program guidelines were not met or were exceeded.	None	
<b>B5</b>	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	522	Not covered because coverage requirements and/or plan/program guidelines were not met.
<b>B7</b>	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
<b>B7</b>	<i>Active: 1/1/95 Last Modified: 10/31/98, 09/20/2009</i>	9B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
<b>B8</b>	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Active: 1/1/95 Modified: 9/30/07, 09/20/2009</i>	None	
<b>B9</b>	Patient is enrolled in a Hospice.	None	
<b>B9</b>	<i>Active: 1/1/95 Modified: 9/30/07</i>	9B9	Services not covered because the patient is enrolled in Hospice.
<b>B10</b>	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. <i>Active: 1/1/95</i>	None	
<b>B11</b>	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. <i>Active: 1/1/95</i>	None	
<b>B12</b>	Services not documented in patient's medical records. <i>Active: 1/1/95</i>	None	
		9B1	Services not documented in patient's medical records.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B12		9E1	Services not documented in patient's medical records.
B12		9E2	Time not (or not correctly) documented. Code billed based on amount of time performed. Documentation incomplete, services not supported.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	None	
	<i>Active: 1/1/95</i>		
B14	Only one visit or consultation per physician per day is covered.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>		
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95 Modified: 10/31/06, 9/30/07, 09/20/2009</i>		
B16	New Patient' qualifications were not met.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	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.
B18	<i>This procedure code/modifier was invalid on the date of service or claim submission.</i>	None	
	<i>Active: 1/1/95 Modified: 9/30/07   Stop: 03/01/2009</i>		
B20	Procedure/service was partially or fully furnished by another provider.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>		
B22	This payment is adjusted based on the diagnosis.	None	
	<i>Active: 1/1/95 Last Modified: 2/28/01</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
<b>B23</b>	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. <i>Active: 1/1/95 Modified: 2/28/01</i>	<b>None</b>	
<i>D16</i>	<i>Claim lacks prior payment information.</i> <i>Active: 1/1/95 Deactivated: 6/30/07</i>	<b>None</b>	
<i>D17</i>	<i>Claim/Service has invalid non-covered days.</i> <i>Active: 1/1/95 Deactivated: 6/30/07</i>	<b>None</b>	
<i>D18</i>	<i>Claim/Service has missing diagnosis information.</i> <i>Active: 1/1/95 Deactivated: 6/30/07</i>	<b>None</b>	
<i>D19</i>	<i>Claim/Service lacks Physician/Operative or other supporting documentation.</i> <i>Active: 1/1/95 Deactivated: 6/30/07</i>	<b>None</b>	
<i>D20</i>	<i>Claim/Service missing service/product information.</i> <i>Active: 1/1/95 Deactivated: 6/30/07</i>	<b>None</b>	
<i>D22</i>	<i>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</i> <i>Active: 1/27/08 To Be Deactivated: 1/1/09</i>	<b>None</b>	
<b>D23</b>	<b>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.)</b> <i>Start: 11/01/2009   Stop: 01/01/2012</i>		
<b>W1</b>	Worker's Compensation State Fee Schedule Adjustment. <i>Active: 2/29/00</i>	<b>None</b>	