HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
1	Deductible Amount.	None	
1	*Active: 1/1/95*	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	*Active: 1/1/95*	010	Reduced coinsurance
2		011	Increased coinsurance
2		D09	Increased dental coinsurance
2		D10	Decreased dental coinsurance
2			
3	Co-payment Amount.	None	
3	*Active: 1/1/95*	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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 1/1/95 | Last Modified 09/20/09*	**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.
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	*Active: 1/1/95 Last Modified 09/20/09*	**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	*Active: 1/1/95 Last Modified 09/20/09*	**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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 1/1/95 Last Modified 09/20/09*	**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	*Active: 1/1/95 Last Modified 09/20/09*	**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	*Active: 1/1/95 Last Modified 09/20/09*		
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	*Active: 1/1/95 Last Modified 09/20/09*	**N14**	This service is not covered for this member.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 1/1/95 Last Modified 09/20/09*	**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**	
	Active: 1/1/95 Last Modified 09/20/09		
13	The date of death precedes the date of service.	**None**	
	Active: 1/1/95		
14	The date of birth follows the date of service.	**None**	
14	*Active: 1/1/95*	**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**	
	Active: 1/1/95 *Modified: 2/28/01, 09/30/07*		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 1/1/95 Modified: 6/30/06 Effective 4/1/07 a Remark Code must be provided.*	**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 drus 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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
16		**60U**	Provider is requested to submit claim for pricing to: OptumHealth Care Solutions, PO Box 30758, Salt Lake City, UT 84130.
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.
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**	
	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.		
18	Duplicate claim/service.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
18	*Active: 1/1/95*	**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**	
	Active: 1/1/95 Modified: 9/30/07	**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	*Active: 1/1/95 Modified: 9/30/07*	**07M**	Please submit this claim to your auto insurance carrier for a determination of their benefits.
20		**153**	No payment is provided because the charge(s) are expected to be paid by the third party liability carrier.
20		**154**	No payment is provided because the charge(s) are expected to be paid out of the third party settlement.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.	**None**	
	Active: 1/1/95 Modified: 09/30/07		
22	This care may be covered by another payer per coordination of benefits.	**None**	
22	*Active: 1/1/95.* *Modified: 2/28/01, 09/30/07*	**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.	**None**	
23	*Active: 1/1/95.* *Modified: 6/30/05, 09/30/07*	**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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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**	
	Active: 1/1/95. *Modified: 6/30/00, 09/30/07*	**751**	Capitation applied.
25	*Payment denied. The stoploss deductible has not been met.*	**None**	
	Active: 1/1/95 Deactivate: 4/1/08		
26	Expenses incurred prior to coverage.	**None**	
26	*Active: 1/1/95*	**S11**	The member's coverage was not in effect on the date service was provided.
26		**S12**	The member's coverage was not in effect on the date service was provided.
26		**S14**	The member's coverage was not in effect on the date service was provided.
26		**S1C**	The member's coverage was not in effect on the date service was provided.
26		**S20**	The date of service is prior to the effective date of coverage.
26		**S21**	The member's coverage was not in effect on the date service was provided.
26		**S22**	The member's coverage was not in effect on the date service was provided.
26		**S23**	The member's coverage was not in effect on the date service was provided.
27	Expenses incurred after coverage terminated.	**None**	
27	*Active: 1/1/95*	**S10**	The member's coverage was not in effect on the date service was provided.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
27		**S17**	The member's coverage was not in effect on the date service was provided.
27		**S1D**	The member's coverage was not in effect on the date service was provided.
27		**S1E**	The member's coverage was not in effect on the date service was provided.
27		**S1F**	The member's coverage was not in effect on the date service was provided.
27		**S8**	The member's age is beyond the limiting age of the plan.
27		**S9**	Group no longer eligible.
27		**SD1**	The member's coverage was not in effect on the date service was provided.
27		**SM**	Coverage is no longer in force.
27		**SM1**	The member's coverage was not in effect on the date service was provided.
27		**SO**	Member no longer eligible. Please check ID card.
27		**SQ**	The patient is no longer eligible.
27		**SS**	Member not eligible for benefits.
27		**SW**	Member not eligible for benefits.
29	The time limit for filing has expired.	**None**	
	Active: 1/1/95	**TF0**	Timely-filing not met. Claim submitted after contract time limit.
30	*Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.*		
	Active: 1/1/95 Deactivated: 2/1/06. Replaced by 177,178,179 & 180		
31	Patient cannot be identified as our insured.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
31	*Active: 1/1/95 Modified: 09/30/07*	**22M**	Our records indicate the patient eligibility is under a plan with dental coverage only.
31		**872**	OEA's records reflect this patient is not covered. Please contact you r school district.
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	*Active: 1/1/95*	**871**	OEA choice trust shows no proof of dependent status.
32		**S6**	Dependent is over maximum age.
33	Insured has no dependent coverage.	**None**	
	Active: 1/1/95 Modified: 9/30/07	**SC**	Member only coverage.
34	Insured has no coverage for newborns.	**None**	
	Active: 1/1/95 Modified: 09/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
35	Lifetime benefit maximum has been reached.	**None**	
35	*Active: 1/1/95 Last Modified: 10/31/02*	**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	*Active: 1/1/95 Last Modified: 6/30/03*	**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	*Active: 1/1/95*	**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	*Active: 1/1/95 | Last Modified: 09/20/2009*	**M13**	Per medical record review, the service does not meet emergency room criteria. Benefit has been made for the assessment fee.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
40		**M15**	Per medical record review, the service does not meet emergency room criteria. No benefits issued.
42	*Charges exceed our fee schedule or maximum allowable amount.*	**None**	
	Active: 1/1/95 Modified: 10/01/06. Deactivated 6/1/07		
43	*Gramm-Rudman reduction.*		
	Active: 1/1/95 Deactivated: 7/1/06		
44	Prompt-pay discount.	**None**	
	Active: 1/1/95		
45	Charges exceed fee schedule / maximum allowable amount or contracted / legislated fee arrangement.	**None**	
45	*Active: 1/1/95. Last Modified: 10/31/06 (Change eff. 6/1/07)*	**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.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		563	Service/item noncovered by Medicate 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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
45		D01	Dental allowable-provider.
45		E8M	Provider discount has been applied.
45		GDM	Processed with ODS contract #111.
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.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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**	
	Active: 1/1/95 | Last Modified: 09/20/2009		
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	*Active: 1/1/95 | Last Modified: 09/20/2009*	**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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 1/1/95 | Last Modified: 09/20/2009*	**17M**	Individual Contestability Exclusion
51		**18M**	Pre-existing condition not covered for period specified by the plan. The member has not provided creditable coverage information.
51		**40M**	Pre-existing condition not covered for period specified by the plan. The member has not provided creditable coverage information.
51		**906**	Pre-existing conditions are not covered.
52	*The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.*	**None**	
	Active: 1/1/95 Deactivated: 2/1/06. Replaced by 170, 183, 184 & 185.		
53	Services by an immediate relative or a member of the same household are not covered.	**None**	
	Active: 1/1/95		
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**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
54	*Active: 1/1/95 | Last Modified: 09/20/2009*	**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**	
55	*Active: 1/1/95 Modified: 09/30/07, 09/20/2009*	**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**	
	Active: 1/1/95 Modified: 09/30/07, 09/20/2009	**814**	Based on consultant review treatment does not have good prognosis.
57	*Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.*	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 1/1/95 Deactivated: 6/30/07 *Split into codes 150, 151, 152, 153 and 154*		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Active: 1/1/95 *Modified: 2/28/01, 09/30/07, 09/20/2009*		
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	*Active: 1/1/95* *Modified: 2/28/07, 09/30/07, 09/20/2009*	**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.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
60	Charges for outpatient services with this proximity to inpatient services are not covered.	**None**	
	Active: 1/1/95		
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.	**None**	
	Active 1/1/95. *Modified: 6/30/00, 09/30/07, 09/20/2009*		
62	*Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.*	**None**	
	Active: 1/1/95 Last Modified: 10/31/06 *Deactivated: 4/1/07*		
66	Blood deductible.	**None**	
	Active: 1/1/95		
69	Day outlier amount.	**None**	
	Active: 1/1/95		
70	Cost outlier - Adjustment to compensate for additional costs.	**None**	
	Active: 1/1/95 Last Modified: 6/30/01	**OUT**	Outlier Pricing.
74	Indirect Medical Education Adjustment.	**None**	
	Active: 1/1/95		
75	Direct Medical Education Adjustment.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 1/1/95		
76	Disproportionate Share Adjustment.	**None**	
	Active: 1/1/95		
78	Non-covered days/room charge adjustment.	**None**	
	Active: 1/1/95	**124**	Plan allows up to semi-private room rate.
85	Interest amount.	**None**	
	Active: 1/1/95		
87	Transfer amount.	**None**	
	Active: 1/1/95 | Last Modified: 09/20/2009 | Stop: 01/01/2012		
88	*Adjustment amount represents collection against receivable created in prior overpayment.*	**None**	
	Active: 1/1/95 | Deactivated: 6/30/07		
89	Professional fees removed from charges.	**None**	
	Active: 1/1/95		
89		**WGZ**	This automated lab test is not eligible for separate professional payment.
90	Ingredient cost adjustment.	**None**	
	Active: 1/1/95		
91	Dispensing fee adjustment.	**None**	
	Active: 1/1/95		
94	Processed in Excess of charges.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
94	*Active: 1/1/95*	**PAI**	The charge exceeds the contracted amount for this service.
94		**PAR**	The charge exceeds the contracted amount for this service.
95	Plan procedures not followed.	**None**	
	Active: 1/1/95 *Modified: 6/30/00, 09/30/07*	**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	*Active: 1/1/95 Modified: 6/30/06, 09/20/2009*	**03D**	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
96		**044**	This request for a referral was denied.
96		**065**	This is not a covered HRA service.
96		**066**	Not covered under Medical Plan--to be paid as 'HRA Only' service.
96		**068**	No Pledge Amount for this HealthCare Expense.
96		**069**	No Pledge Amount for the Dependent Care Expense.
96		**073**	Deny All Claim Lines.
96		**122**	The plan allows preventive health care benefits only when services are provided by the Primary Care Physician (PCP).

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		**811**	Payment is provided for a complete series x-rays (including panoramic) once in a three year period.
96		**812**	Payment for an examination fee includes the use of diagnostic aids, except for x-rays, study models and certain lab test.
96		**813**	Payment is provided for study models for cases involving three or more missing teeth (not full dentures). Limited to one every five years.
96		**816**	Payment is provided for a single surface restoration in each episode of treatment regardless of the number of restorations placed.
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.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		**E68**	Paymet 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	*Active: 1/1/95* *Modified: 10/31/06, 09/30/07, 09/20/2009*	**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		**711**	This service is not eligible on the day of discharge.
97		**721**	The surfaces must be combined and billed, one line per tooth, using appropriate code.
97		**752**	Audit results. This item not eligible or never eligible to be separately reported or never eligible for separate reimbursement.
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.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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).
97		N01	The charges for this procedure have been considered as part of another more comprehensive procedure code.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
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 obstetic care service and should not be reported separately.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
100	Payment made to patient/insured/responsible party.	**None**	
	Active: 1/1/95		
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	**None**	
101	*Active: 1/1/95 Last Modified: 2/28/99*	**909**	Treatment plan 1.
101		**910**	Treatment plan 2.
102	Major Medical Adjustment.	**None**	
	Active: 1/1/95		
103	Provider promotional discount (i.e. Senior citizen discount).	**None**	
	Active: 1/1/95 Last Modified: 6/30/01		
104	Managed care withholding.	**None**	
	Active: 1/1/95		
105	Tax withholding.	**None**	
	Active: 1/1/95		
106	Patient payment option/election not in effect.	**None**	
	Active: 1/1/95		
107	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.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
107	*Active: 1/1/95* *Modified: 10/31/06, 09/30/07, 09/20/2009*	**WGJ**	The procedure (add-on) code is not allowed separately. The required primary code was not billed for the same date of service.
108	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.	**None**	
108	*Active: 1/1/95 Last Modified: 6/30/02, 09/20/2009*	**89M**	The plan covers rental (not to exceed the reasonable purchase price) of medically necessary durable medical equipment.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	**None**	
109	*Active: 1/1/95*	**054**	Services denied due to being delegated to another entity.
109		**108**	This plan has terminated. Please submit the claim to the new insurance carrier.
109		**40E**	Provider is requested to submit claim to Valueoptions: PO Box 1290, Lathan, NY 12110. For more information call 1-800-892-8804.
109		**450**	Not covered under the dental plan. Service may be eligible for reimbursement under the member's Health Reimbursement Account.
		508	Part D service. Please bill patient.
110	Billing date predates service date.	**None**	
	Active: 1/1/95		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
111	Not covered unless the provider accepts assignment.	**None**	
	Active: 1/1/95		
112	Service not furnished directly to the patient and/or not documented.	**None**	
	Active: 1/1/95 Modified: 09/30/07		
113	*Payment denied because service/procedure was provided outside the United States or as a result of war.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07. Replaced by 157, 158 or 159.		
114	Procedure/product not approved by the Food and Drug Administration.	**None**	
	Active: 1/1/95		
115	Procedure postponed, canceled or delayed.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 09/30/07		
116	The advance indemnification notice signed by the patient did not comply with requirements.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 09/30/07		
117	Transportation is only covered to the closest facility that can provide the necessary care.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 09/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
118	ESRD network support adjustment.	**None**	
	Active: 1/1/95 Modified: 09/30/07		
119	Benefit maximum for this time period has been reached.	**None**	
119	*Active: 1/1/95 Last Modified: 2/29/04*	**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.
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 prenatel/child birthing classes has been met. Patient responsibility applied.
119		**45M**	Inpatient maximum for this condition has been reached.
119		**79M**	Maximum benefit has been reached for this type of service.
119		**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.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		8B3	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a 36 month period.
119		8B6	Photographs are a benefit once in a fice year period and limited to a $35.00 maximum.
119		8B7	Benefit is limited to Ten (10) in a Twelve (12) month period.
119		8D3	Limited to once per visit.
119		925	The maximum allowed for services of this type has been reached.
119		953	Benefit is Limited to two (2) times per year.
119		955	Implant maximum has been met for this benefit year.
119		971	Emergency services performed by an out of network provider are linited to a $100.00 maximum benefit.
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.

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

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		L54	Sports Therapy service maximum has been met for this benefit period.
119		L55	Hearing Aid maximum has been met for this benefit period.
119		L56	Hearing exam service maximum has been met for this benefit period.
119		L57	Extended care service maximum has been met for this benefit period.
119		L58	Home health service maximum has been met for this benefit period.
119		L59	Well baby exam maximum has been met for this benefit period.
119		L5A	Prescription self-injectables annual maximum has been met.
119		L5B	Ambulance service maximum has been met for this benefit period.
119		L5D	Skilled nursing facility maximum has been met for this benefit period.
119		L5E	Acupuncture, naturopath and/or licensed massage therapist service maximum has been met for this benefit period.
119		L5F	Well child exam maximum has been met for this benefit period.
119		L60	Individual medical out of pocket maximum has been met.
119		L61	Family medical out of pocket maximum has been met.
119		L62	Individual medical out of network out of pocket maximum has been met.
119		L63	Family medical out of network out of pocket maximum has been met.
119		L64	Individual hospital out of pocket maximum has been met.
119		L65	Family hospital out of pocket maximum has been met.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		
121	Indemnification adjustment.	**None**	
	Active: 1/1/95		
122	Psychiatric reduction.	**None**	
	Active: 1/1/95		
123	Payer refund due to overpayment.	**None**	
	Active: 1/1/95 Deactivate: 6/30/07		
124	Payer refund amount - not our patient.	**None**	
	Active: 1/1/95 Last Modified: 6/30/99 Deactivate: 6/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code)	**None**	
125	*Active: 1/1/95* *Modified: 6/30/06, 09/30/07*	**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	**None**	
	Active: 2/28/97		
127	Coinsurance -- Major Medical	**None**	
	Active: 2/28/97		
128	Newborn's services are covered in the mother's Allowance.	**None**	
	Active: 2/28/97		
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.)	**None**	
	Active: 2/28/97 *Modified: 2/28/01, 09/30/07*		
130	Claim submission fee.	**None**	
	Active: 2/28/97 Last Modified: 6/30/01	**803**	A separate fee for completion of a claim form is not covered.
131	Claim specific negotiated discount.	**None**	
131	*Active: 2/28/97*	**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.

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

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

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W27	Paid according to your PPO contract with NPPN/Universal/NV.
131		W28	Paid according to your PPO contract with NPPN/TRPN.
131		W29	Paid according to your PPO contract with NPPN/American Care Source.
131		W2A	Paid according to your PPO contract with MR/National Provider Network.
131		W2B	Paid according to your PPO contract with MR/ppoNEXT.
131		W2C	Paid according to your PPO contract with MR/Prime Health Services.
131		W2D	Paid according to your PPO contract with MR/Provider Select Inc.
131		W2E	Paid according to your PPO contract with MR/The Health Payors Organization
131		W2F	Paid according to your PPO contract with NPPN/American PPO
131		W2G	Paid according to your PPO contract with NPPN/Independent Medical System..
131		W2H	Paid according to your PPO contract with NPPN/TRPN/ASPA
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W2O	Paid according to your PPO contract with TRPN/HFN.
131		W2P	Paid according to your PPO contract with TRPN/Integrated Health Plan.
131		W2Q	Paid according to your PPO contract with TRPN/Managed Care Strategies.
131		W2R	Paid according to your PPO contract with TRPN/National Provider Network.
131		W2S	Paid according to your PPO contract with TRPN/Ohio Preferred Network.
131		W2T	Paid according to your PPO contract with TRPN/Preferred Mental Health Network.
131		W2U	Paid according to your PPO contract with TRPN/Prime Health Services.
131		W2V	Paid according to your PPO contract with TRPN/Quality Healthcare Partnership.
131		W2W	Paid according to your PPO contract with TRPN/Universal Health Network..
131		W2X	Paid according to your PPO contract with Three Rivers Provider Network (TRPN).
131		W2Y	Paid according to your PPO contract with TRPN/Initial Group.
131		W2Z	Paid according to your PPO contract with TRPN/FCHN.
131		W30	Paid according to your PPO contract with NPPN/Healthcare Network of America.
131		W31	Paid according to your PPO contract with NPPN/PCC PPO.
131		W32	Paid according to your PPO contract with NPPN/MRI.

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

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

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
131		W4W	Paid according to your PPO contract with IHP/Health Care Network of America.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W5E	Paid according to your PPO contract with IHP/Preferred Care.
131		W5F	Paid according to your PPO contract with IHP/Preferred Care - Aiken SC.
131		W5G	Paid according to your PPO contract with IHP/Prime Health Services Inc.
131		W5H	Paid according to your PPO contract with IHP/ Provider Select Inc.
131		W5I	Paid according to your PPO contract with IHP/ TLC Advantage.
131		W5J	Paid according to your PPO contract with NPPN/Belin Health & Thedacare.
131		W5K	Paid according to your PPO contract with IHP/Medlink.
131		W5L	Paid according to your PPO contract with IHP/PSI/UHN.
131		W5M	Paid according to your PPO contract with IHP/FEDMED.
131		W5N	Paid according to your PPO contract with Provider Select (PSI).
131		W5O	Paid according to your PPO contract with PMCS Networks.
131		W5P	Paid according to your PPO contract with America's PPO.
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.

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

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W74	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica.
131		W75	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica (Shared Savings).
131		W76	Paid according to your PPO contract with NCN/Multiplan.
131		W77	Paid according to your PPO contract with NCN/American Care Source (ACS).
131		W78	Paid according to your PPO contract with Concentra/Multiplan.
131		W79	Paid according to your PPO contract with NPPN/Healthcare Direct.
131		W7A	Paid according to your PPO contract with ACPN.
131		W7B	Paid according to your PPO contract with USAMCO.
131		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 Mulitplan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
132	Prearranged demonstration project adjustment.	**None**	
	Active: 2/28/97		
133	The disposition of this claim/service is pending further review.	**None**	
	Active: 2/28/97 Last Modified: 10/31/99	**52**	Pending hospital audit.
134	Technical fees removed from charges.	**None**	
	Active: 10/31/98		
135	Interim bills cannot be processed.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 10/31/98 Modified: 09/30/07	**19M**	Benefits cannot be considered until OB care has been completed. Please submit claim at that time.
		527	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)	**None**	
	Active: 10/31/98 *Modified: 10/31/06, 09/30/07*		
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	**None**	
	Active: 2/28/99 Modified: 09/30/07		
138	Appeal procedures not followed or time limits not met.		
138	*Active: 6/30/99 Modified: 09/30/07*	**H38**	Claim/service denied. Appeal procedures not followed or time limits not met.
138		**H39**	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.	**None**	
	Active: 6/30/99		
140	Patient/Insured health identification number and name do not match.	**None**	
	Active: 6/30/99		
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
	Active: 6/30/99 *Modified: 6/30/00, 09/30/07*		
142	Monthly Medicaid patient liability amount.	**None**	
	Active: 6/30/00 Modified: 09/30/07		
143	Portion of payment deferred.	**None**	
	Active: 2/28/01		
144	Incentive adjustment, e.g. preferred product/service.	**None**	
	Active: 6/30/01		
145	Premium payment withholding.	**None**	
	Active: 6/30/02		
146	Diagnosis was invalid for the date(s) of service reported.	**None**	
146	*Active: 6/30/02 Modified: 09/30/07*	**118**	No CPT/HCPCS code billed. According to the UB04 manual, this revenue code requires a CPT/HCPCS code. Please resubmit.
146		**992**	Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis
147	Provider contracted/negotiated rate expired or not on file.	**None**	
	Active: 6/30/02		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**None**	
	Active: 6/30/02 Modified: 09/30/07, 09/20/2009		
149	Lifetime benefit maximum has been reached for this service/benefit category.	**None**	
149	*Active: 10/31/02*	**L12**	TMJ service maximum has been met.
149		**L2B**	Lifetime major medical out of network maximum has been met. No further benefits are available.
149		**L2C**	Chemical dependency lifetime maximum has been met. No further benefits are available.
149		**L2D**	Mental health lifetime maximum has been met
149		**L30**	Dental lifetime maximum has been met.
149		**L31**	Dental lifetime maximum has been met.
149		**L33**	Periodontal lifetime maximum has been met.
149		**L34**	TMJ lifetime maximum has been met.
149		**L35**	Orthodontic lifetime maximum has been met.
149		**L4A**	Diabetes self management lifetime maximum has been met.
149		**L4B**	Bio feedback lifetime maximum has been met.
149		**L6A**	Donor cost lifetime maximum has been met.
149		**L6B**	Pharmacy lifetime maximum has been met.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07*	**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	*Active: 10/31/02. Modified: 09/30/07, 01/27/2008*	**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**	
	Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07		
153	Payer deems the information submitted does not support this dosage.	**None**	
	Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07		

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 2/29/04		
163	Attachment referenced on the claim was not received.	**None**	
	Active: 6/30/04 Modified: 09/30/07		
164	Attachment referenced on the claim was not received in a timely fashion.	**None**	
	Active: 6/30/04 Modified: 09/30/07		
165	Referral absent or exceeded.	**None**	
	Active: 10/31/04 Modified: 09/30/07		
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	**None**	
166	*Active: 2/28/05*	**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	*Active: 6/30/05 | Last Modified: 09/20/2009*	**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**	
	Active: 02/01/06 Modified: 09/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
169	Alternate benefit has been provided.	**None**	
169	*Active: 02/01/06 Modified: 09/30/07*	**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. A llowance has been made for a silver (amalgam) filling.
169		**823**	Porcelain crowns, if posterior to the upper first molar and the lower second bicuspid are optional. Benefit is for a full gold crown.
169		**840**	An alternative benefit has been provided based on the contract limitation.
169		**842**	Payment is not provided for transitional dentures, treatment dentures, or temporary dentures. Reline benefit is provided.
169		**843**	Overdentures are allowed based on the fee for a standard denture plus an allowance for root canal therapy per overdenture.
169		**892**	Porcelain/resin onlays on posterior teeth are optional. Benefit is provided for a metallic onlay.
169		**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**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
170	*Active: 6/30/05 | Last modified: 09/20/2009*	**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**	
	Active: 6/30/05 | Last Modified: 09/20/2009		
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**	
	Active: 6/30/05 | Last Modified: 09/20/2009		
173	Service was not prescribed by a physician.	**None**	
	Active: 02/01/06 Modified: 09/30/07		
174	Service was not prescribed prior to delivery.	**None**	
	Active: 02/01/06 | Modified: 09/30/07		
175	Prescription is incomplete.	**None**	
	Active: 02/01/06 | Modified: 09/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
176	Prescription is not current.	**None**	
	Active: 02/01/06 | Modified: 09/30/07		
177	Patient has not met the required eligibility requirements.	**None**	
177	*Active: 02/01/06 | Modified: 09/30/07*	**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**	
	Active: 02/01/06 | Modified: 09/30/07		
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	*Active: 02/01/06 | Modified: 09/30/07, 09/20/2009*	**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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
180	Patient has not met the required residency requirements.	**None**	
	Active: 02/01/06 | Modified: 09/30/07		
181	Procedure code was invalid on the date of service.	**None**	
181	*Active: 02/01/06 Modified: 09/30/07*	**N13**	This procedure is not a covered service under your plan.
182	Procedure modifier was invalid on the date of service.	**None**	
	Active: 02/01/06. *Modified: 8/8/05, 09/30/07*		
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**	
	Active: 6/30/05 | Last Modified: 09/20/2009		
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**	
	Active: 6/30/05 | Last Modified: 09/20/2009		
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**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 6/30/05 | Last Modified: 09/20/2009		
186	Level of care change adjustment.	**None**	
	Active: 02/01/06 Modified: 09/30/07		
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	**None**	
	Active: 6/30/05 | Last Modified: 01/25/2009		
188	This product/procedure is only covered when used according to FDA recommendations.	**None**	
	Active: 6/30/05		
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	*Active: 6/30/05*	**12E**	"Not otherwise classified" or "unlisted" CPT/HCPCS code billed. Specific code available for this procedure/service. Please rebill.
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.	**None**	
	Active: 10/31/05		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
191	Not a work related injury/illness and thus not the liabilityof the worker's compensation carrier.	**None**	
	Active: 10/31/05 Modified: 09/30/07		
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.	**None**	
	Active: 10/31/05 Modified: 09/30/07		
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	**None**	
	Active: 2/28/06 | Last Modified: 01/27/2008		
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	**None**	
	Active: 02/28/06 Modified: 09/30/07		
195	Refund issued to an erroneous priority payer for this claim/service.	**None**	
	Active: 02/28/06 Modified: 09/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
196	*Claim/service denied based on prior payer's coverage determination.*	**None**	
	Active: 6/30/06 Deactivated: 2/1/07 Use code 136		
197	Precertification/authorization/notification absent.	**None**	
197	*Active: 10/31/06 | Last Modified: 09/30/07*	**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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
197		**UM2**	Units were reduced by a utilization management authorization.
198	Precertification/authorization exceeded	**None**	
198	*Active: 10/31/06 | Modified: 09/30/07*	**95**	Level of service billed does not match level of service authorized.
199	Revenue code and Procedure code do not match.	**None**	
	Active: 10/31/06		
200	Expenses incurred during lapse in coverage.	**None**	
	Active: 10/31/06		
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**	
	Active: 10/31/06		
202	Non-covered personal comfort or convenience services.	**None**	
202	*Active: 2/28/07 Modified: 9/30/07*	**504**	Personal comfort items are not covered.
203	Discontinued or reduced service.	**None**	
	Active: 2/28/07 Modified: 9/30/07		
204	The service/equipment/drug is not covered under the patient's current benefit plan.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204	*Active: 2/28/07*	02M	Classes and other educational/instructional services or materials are not covered.
204		09N	This service/expense is not covered
204		11M	Non-covered drug/supply.
204		125	State and/or local taxes are not covered.
204		12M	There is no benefit for mailing or handling fees.
204		25M	No coverage for telephone consultation.
204		26M	Charges for missed appointments are not covered.
204		27M	Routine immunization not covered.
204		29M	Medications not requiring a doctor's prescription are excluded by the plan.
204		38M	Charges for reports and/or finance charges are not covered.
204		516	Non-durable medical equipment is not covered.
204		518	No coverage for cosmetic services or supplies.
204		519	This preventive health care service is not covered.
204		521	Maximum benefit has been reached for this type of service.
204		531	Diagnosis on claim not covered by Medicare/ODS Advantage. Claim indicates you were informed of this in writing so you must pay this charge.
204		535	Service/item noncovered by Medicare/ODS Advantage. The provider indicates you were notified of this in advance and you agreed to pay.
204		536	Medicare/ODS Advantage does not cover acupuncture services. Claim indicates you were notified of this in advance and you agreed to pay.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		537	Medicare/ODS Advantage does not cover hearing aids or routine hearing exams. Claim indicates you were notified of this and agreed to pay.
204		538	The provider billed this charge as non-covered and indicates you were notified in advance this was not covered and you agreed to pay.
204		539	Medicare/ODS Advantage does not cover this surgical procedure for obesity. Other procedures are covered when requirements are met.
204		540	This provider is not approved to perform MTM services under this plan. ODS Advantage MTM services are performed by in-house staff only.
204		542	Medicare covers another similar item, but this upgrade model or version is not covered. Claim indicates you were notified and agreed to pay.
204		543	Medicare/ODS Advantage does not cover this method of monitoring your diabetes. Benefits available for blood glucose testing supplies.
204		544	Medicare/ODS Advantage does not cover services, items, or medications to prevent pregnancy.
204		545	Medicare/ODS Advantage does not cover food allergy testing and treatment.
204		546	Medicare/ODS Advantage does not cover transportation in vehicle other than ambulance.
204		547	Medicare/ODS Advantage covers transportation only to the closest facility that can provide the necessary care.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		548	This item is for use as a compression/surgical dressing and is not covered by Medicare/ODS Advantage.
204		549	Medicare/ODS Advantage covers CPM devices only for the knee and not for this joint or body part.
204		550	Our records show that the date and/or time of death was before the date or time of service.
204		551	Medicare/ODS Advantage does not cover these ancillary (miscellaneous related supplemental) ambulance services/charges.
204		552	Medicare/ODS Advantage does not cover this type of treatment for infertility or services/items to help with becoming pregnant.
204		553	Medicare/ODS Advantage does not pay for online or telephone evaluation and management services such as this.
204		554	Medicare/ODS Advantage does not pay for these services because there was no direct patient treatment and/or contact involved.
204		555	Medicare/ODS Advantage does not cover rehabilitation services for this disease or condition.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 measure ment. Another covered test is available and should have been used.
204		565	This vision service is not covered for a routine vision diagnosis by Original Medicare or your ODS Advantage plan.
204		566	The covered portion of this item/service is billed under another code. This portion/upgrade feature is not covered under your plan.
204		567	This is a routine service that does not fall within the list of routine services covered by Original Medicare or your ODS Advantage plan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		568	Medicare considers this a personal comfort item and not a covered benefit under Medicate/ODS Advantage. Claim indicates you agreed to pay.
204		569	This item has been forwarded for processing under Part D.
204		570	This medication or item is covered under Medicare Part D. Your ODS Advantage plan does not include Part D coverage.
204		571	The information provided does not support that you meet the criteria to be considered homebound.
204		572	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 diagnoisis 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 serivce/supply.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		**80D**	Accident related procedures are not covered under this dental plan.
204		**815**	No payment is provided for the following fees: periodontal charting, office calls, consultations, or broken appointments.
204		**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.	**None**	
	Active: 7/9/07		
206	National Provider Identifier - missing.	**None**	
	Active: 7/9/07 Modified: 9/30/07		
207	National Provider Identifier - Invalid format.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 7/9/07 Modified: 9/30/07 Deactivate: 05/23/08		
208	National Provider Identifier - Not matched.	**None**	
	Active: 7/9/07 Modified: 9/30/07		
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	**None**	
	Active: 7/9/007		
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	**None**	
	Active: 7/9/07		
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	**None**	
	Active: 7/9/07		
212	Administrative surcharges are not covered.	**None**	
	Active: 11/05/07		
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	**None**	
	Active: 1/27/08		
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**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 1/27/08		
215	Based on subrogation of a third party settlement	**None**	
215	*Active: 1/27/08*	**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**	
	Active: 1/27/08		
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**	
	Active: 1/27/08		
218	Based on entitlement to benefits. (Note: To be used for Workers' Compensation only)	**None**	
	Active: 1/27/08		
219	Based on extent of injury. (Note: To be used for Workers' Compensation only)	**None**	
	Active: 1/27/08		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	**None**	
	Active: 1/27/08		
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	**None**	
	Active: 1/27/08		
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.		
	Active: 6/1/08 | Last Modified: 09/20/2009		
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.		
	Active: 6/1/08		
224	Patient identification compromised by identity theft. Identify verification required for processing this and future claims.		
	Active: 6/1/08		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)		
	Active: 6/1/08		
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	*Start: 09/21/2008 | Last Modified: 09/20/2009*	**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 neceesity.
226		**933**	Narrative, current periapical x-ray and diagnosis of the treatment was not received from the provider to confirm neceesity.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		934	Pathology report, narrative and location of the tissue being removed was not received from the provider to confirm neceesity.
226		935	Periodontal charting, narrative, diagnosis and date of last periodontal therapy was not received from the provder.
226		936	Periodontal charting, periapical x-ray, narrative and diagnosis was not received from the provder to confirm necessity.
226		937	Periodontal charting, periapical x-ray of the abutment teeth and the opposing arch was not received from the provder to confirm necessity
226		938	Narrative including the material used was not receied form 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.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	*Start: 09/21/2008 | Last Modified: 09/20/2009*	**48A**	Information requested from the member about accident details for the conditions on this claim has not been received.
227		**48B**	Information requested from the member about other insurance coverage has not been received.
227		**48D**	Information requested from the member on the accident claim letter has been received, but was incomplete.
227		**48I**	Information requested from the member on the student verification form has been received but was incomplete.
227		**48S**	Information requested from the member 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	**None**	
	Start: 09/21/2008		
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.		
	Start: 01/25/2009		
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.		
	Start: 01/25/2009		
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.		
	Start: 07/01/2009 | Last Modified: 09/20/2009		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.		
	Start: 11/01/2009		
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
	Start: 01/24/2010		
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.)		
	Start: 01/24/2010		
235	Sales Tax		
	Start: 06/06/2010		
A0	Patient refund amount.	**None**	
	Active: 1/1/95		
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**	
	Active: 1/1/95 Last Modified: 10/31/06 Eff 6/1/07 At least one Remark Code must be provided.09/20/2009	**03E**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
A2	*Contractual adjustment.*	**None**	
	Active: 1/1/95 Last Modified: 2/28/07 Deactivated on 1/1/08		
A4	Medicare Claim PPS Capital Day Outlier Amount.	**None**	
	Active: 1/1/95 | Last Modified: 09/30/2007 | Stop: 04/01/2008		
A5	Medicare Claim PPS Capital Cost Outlier Amount.	**None**	
	Active: 1/1/95		
A6	Prior hospitalization or 30 day transfer requirement not met.	**None**	
	Active: 1/1/95		
A7	Presumptive Payment Adjustment.	**None**	
	Active: 1/1/95		
A8	Ungroupable DRG.	**None**	
	Active: 1/1/95 | Last Modified: 09/30/2007		
B1	Non-covered visits.	**None**	
	Active: 1/1/95		
B4	Late filing penalty.	**None**	
	Active: 1/1/95		
B5	Coverage/program guidelines were not met or were exceeded.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B5	*Active: 1/1/95 Modified: 2/28/01, 9/30/07*	**522**	Not covered because coverage requirements and/or plan/program guidelines were not met.
B7	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**	
B7	*Active: 1/1/95 Last Modified: 10/31/98, 09/20/2009*	**9B7**	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	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.	**None**	
	Active: 1/1/95 Modified: 9/30/07, 09/20/2009		
B9	Patient is enrolled in a Hospice.	**None**	
B9	*Active: 1/1/95 Modified: 9/30/07*	**9B9**	Services not covered because the patient is enrolled in Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	**None**	
	Active: 1/1/95		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	**None**	
	Active: 1/1/95		
B12	Services not documented in patient's medical records.	**None**	
	Active: 1/1/95	**9B1**	Services not documented in patient's medical records.
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**	
	Active: 1/1/95		
B14	Only one visit or consultation per physician per day is covered.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 9/30/07		
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**None**	
	Active: 1/1/95 Modified: 10/31/06, 9/30/07, 09/20/2009		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B16	New Patient' qualifications were not met.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 9/30/07	**WGK**	Our records show patient has been treated by this provider/clinic within the past 3 years. Criteria for new patient code has not been met.
B18	*This procedure code/modifier was invalid on the date of service or claim submission.*	**None**	
	Active: 1/1/95 Modified: 9/30/07 | Stop: 03/01/2009		
B20	Procedure/service was partially or fully furnished by another provider.	**None**	
	Active: 1/1/95 Modified: 2/28/01, 9/30/07		
B22	This payment is adjusted based on the diagnosis.	**None**	
	Active: 1/1/95 Last Modified: 2/28/01		
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	**None**	
	Active: 1/1/95 Modified: 2/28/01		
D16	*Claim lacks prior payment information.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07		
D17	*Claim/Service has invalid non-covered days.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
D18	*Claim/Service has missing diagnosis information.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07		
D19	*Claim/Service lacks Physician/Operative or other supporting documentation.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07		
D20	*Claim/Service missing service/product information.*	**None**	
	Active: 1/1/95 Deactivated: 6/30/07		
D22	*Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) -- Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code*	**None**	
	Active: 1/27/08 To Be Deactivated: 1/1/09		
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)		
	Start: 11/01/2009 | Stop: 01/01/2012		
W1	Worker's Compensation State Fee Schedule Adjustment.	**None**	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	Active: 2/29/00		