

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
1	Deductible Amount.	None	
1	<i>Start: 01/01/1995</i>	006	Reduced Deductible
1		007	Increased Deductible.
1		460	Medicare deductible applied.
1		500	Medicare deductible.
1		D05	Increased Dental Deductible.
1		D06	Decrease Dental Deductible.
2	Co-insurance Amount.	None	
2	<i>Start: 01/01/1995</i>	010	Reduced coinsurance
2		011	Increased coinsurance
2		D09	Increased dental coinsurance
2		D10	Decreased dental coinsurance
3	Co-payment Amount.	None	
3	<i>Start: 01/01/1995</i>	004	Reduced copayment
3		005	Increased copayment
3		69M	Benefit based on RX co-pay amount.
3		87M	Individual responsibility co-pay amount.
3		899	Co-pay applied.
3		901	Patient is responsible for \$10.00 office visit.
3		904	Patient is responsible for \$4.00 office visit.
3		D03	Increased dental copayment
3		D04	Decreased dental copayment

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4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
4	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	514	The modifier that was billed is invalid for the procedure.
4		52A	Denied for criteria not met; required modifier is missing.
4		52B	Please resubmit, code is missing modifier or it is invalid for the Therapy service billed.
4		81R	Telemedicine services (place of service code 02) must also be billed with an appropriate telemedicine modifier. Corrected claim needed.
4		N27	The modifier that was billed is invalid for the procedure. Please rebill.
4		WHD	The modifier that was billed is invalid for the procedure.
5	The procedure code/bill type is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
5	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	515	The procedure code and/or bill type is inconsistent with the place of service.

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5		81S	Telemedicine services (modifier GT/GQ/95) must also be billed with place of service 02 (telemedicine). Corrected claim needed.
5		N17	The place of service is inconsistent with the procedure that was performed.
5		WGY	The procedure code, modifier, POS code, and/or bill type is inconsistent with the place of service shown on the claim or in our records.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
6	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	9E3	This service is not covered. Not covered for members under age 16.
6		9E4	Covered only for member's under age 19.
6		9E5	This service is not covered. Not covered for members under age 3.
6		9E6	This Service is not covered. Only covered for members age 12 and under
6		9E7	This service is not covered. Not covered for members under age 16.
6		9E8	Not covered for members under age 16.
6		DPO	The service is not allowed due to the patient's age.

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6		N15	This service is not normally performed for members in this age range.
6		N16	This service is not normally performed for members in this age range.
6		OAS	This service is not normally performed for members in this age range.
6		UAS	The member was not covered under the plan on the date the service was provided.
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
7	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	ISS	This is not a covered service for this member.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
8	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	578	The procedure code is inconsistent with the provider type/specialty (taxonomy).

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8		9H4	Procedure code billed is incorrect according to provider specialty. Please re-bill with appropriate anesthesia code.
8		WHE	The modifier is inconsistent with the provider type/specialty taxonomy).
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
9	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>		
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
10	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	N14	This service is not covered for this member.
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
11	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	46M	The diagnosis is inconsistent with the treatment performed. Please resubmit with the corrected diagnosis.

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11		46N	The diagnosis code billed is not appropriate for the patient's treatment and/or the service billed.
11		68M	This service and/or type of treatment is not covered for this diagnosis.
11		N19	This service is not covered when performed for the reported diagnosis.
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>		
13	The date of death precedes the date of service.	None	
	<i>Start: 01/01/1995</i>		
14	The date of birth follows the date of service.	None	
14	<i>Start: 01/01/1995</i>	S2	The date of service is before member's date of birth.
14		524	Please obtain from provider and send itemization of services, showing medical diagnosis, description, and charge for each service.
15	<i>The authorization number is missing, invalid, or does not apply to the billed services or provider.</i>	None	

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	<i>Start: 01/01/1995 Last Modified: 09/30/2007 Stop 5/1/2018</i>		
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
16	<i>Start: 01/01/1995 Last Modified: 3/1/2018, 07/01/2017</i>	107	The provider is requested to submit a description of this service/supply.
16		109	Please resubmit with a diagnosis.
16		110	A signed, valid consent form required. Please submit with claim.
16		112	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).
16		113	For further consideration, the provider needs to submit chart notes for this date of service.
16		114	A valid NDC code is required for physician administered drug covered by the Oregon Health Plan.
16		117	Please resubmit with a valid CPT/HCPCS code.
16		11E	Please resubmit with a valid CPT/HCPCS code.

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16		140	This code is not valid for commercial plans. Code is specific to Medicare or Medicaid plans. Please resubmit with a valid procedure code.
16		480	Information requested from other provider(s) has not been received.
16		577	Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame.
16		583	The NDC submitted does not match procedure code submitted. Unable to process. Please submit corrected claim with valid NDC/procedure code.
16		584	NDC lacks unit(s) of measure and/or quantity. Submit corrected claim with valid NDC that includes unit(s) of measure and/or quantity.
16		586	Incorrect code billed. A more appropriate unclassified code or a listed code is available. Resubmit with the correct HCPCS code.
16		58M	Please submit medical records for utilization review of pended days.
16		60A	Provider is requested to submit claim for pricing to: LifeTrac 11100 Waysata Blvd Suite 350, Minneapolis, MN 55305.
16		60I	Provider is requested to submit claim for pricing to: INTERLINK Health Services, 4660 NE Belknap Ct. #209, Hillsboro, OR 97214.

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16		60M	Provider is requested to submit claim for pricing to: Cofinity, PO Box 2720, Farmington Hills, MI 48333.
16		60U	Provider submit pricing to OptumHealth Care Solutions. ATTN: Acct. Dept MN010-E133, PO Box 30758, Salt Lake City, UT 84130
16		64M	Received balance due statement only. Please submit itemized charges from this provider.
16		70J	Please resubmit, Service Facility Location Information is missing or is missing or invalid.
16		741	Review. The units billed are invalid because they are not consistent with the procedure code definition.
16		791	A valid NDC code is required.
16		794	A valid NDC code is required.
16		7AS	Please resubmit. Service facility location information is missing or invalid.
16		800	An invalid or wrong code was used. The dentist is requested to submit a correct code.
16		81M	Partial payment only. The remainder of the claim has been returned for additional information.
16		85M	One or more diagnosis codes on this claim requires more digits to be complete. Please resubmit the claims with a more specific diagnosis.

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16		897	Please resubmit with the appropriate ADA code, clinical information, and reason for placement.
16		8A7	This service is not covered. The requested information has not been received from the dentist to confirm need.
16		916	Claim/service lacks information which is needed for adjudication.
16		918	Please submit an invoice for the supply.
16		920	This service is not covered. Chart notes have not been received from the dentist to confirm need.
16		923	An invalid or wrong code was used. The dentist is requested to submit a correct code.
16		970	Lab pathology report is required.
16		N78	Invalid diagnosis code
16		WHC	This CPT/HCPCS is not a valid procedure code for the date of service billed. Please resubmit.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	None	
18	<i>Start: 01/01/1995 Last Modified: 06/02/2013</i>	CDD	This service is a duplicate of a previously processed service or is currently in process. Please check your records.

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18		Q1	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		Q2	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
18		Q3	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	67M	Work related claims are not covered by your plan. Please submit these charges to your Workers' Compensation carrier.
		6M7	Work related claims are not covered by your plan. Please submit these charges to your Workers' Compensation carrier.
20	This injury/illness is covered by the liability carrier.	None	
20	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	07M	Submit to your auto insurance carrier for a determination of their benefits.
20		153	No payment is provided because the charge(s) are expected to be paid by the third party liability carrier.

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20		154	No payment is provided because the charge(s) are expected to be paid out of the third party settlement.
20		155	No payment is provided because the charge(s) are expected to be paid by the motor vehicle carrier.
21	This injury/illness is the liability of the no-fault carrier. <i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	None	
22	This care may be covered by another payer per coordination of benefits.	None	
22	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	57M	Please send Medicare's explanation of benefits for this claim.
22		73P	Coordination of benefits updated; order of benefits changed.
22		74M	Please submit a copy of the primary carrier's explanation of benefits. Your claim will be reviewed/adjusted when we received this information.
22		7A2	Primary and secondary carriers need to be billed first. Please provide copies of all explanation of benefits for further reiew/adjustment.
22		86D	Dental plans are secondary on treatment for accidental injury to the natural teeth. A medical plan's Explanation of Benefits is required.

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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. (Use only with Group Code OA)	None	
23	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	055	Medicare Supplemental Calculation Applied.
23		579	Coverage based on Medicare allowed amount.
23		580	The maximum benefit allowance under the non-duplication provisions is our normal benefit less the amount payable under the primary plan.
23		781	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
23		86A	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
23		9H3	Payment has been reduced based on estimation of Medicare's payment. The member may be responsible for the estimated Medicare payment.
23		COB	Payment limited due to other insurance

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24	Charges are covered under a capitation agreement/managed care plan.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	751	Capitation applied.
25	<i>Payment denied. The stoploss deductible has not been met.</i>	None	
	<i>Start: 01/01/1995 Stop: 04/01/2008</i>		
26	Expenses incurred prior to coverage.	None	
26	<i>Start: 01/01/1995</i>	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.

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26		S23	The member's coverage was not in effect on the date service was provided.
27	Expenses incurred after coverage terminated.	None	
27	Start: 01/01/1995	S8	The member's age is beyond the limiting age of the plan.
27		S9	Group no longer eligible.
27		S10	The member's coverage was not in effect on the date service was provided.
27		S17	The member's coverage was not in effect on the date service was provided.
27		S1D	The member's coverage was not in effect on the date service was provided.
27		S1E	The member's coverage was not in effect on the date service was provided.
27		S1F	The member's coverage was not in effect on the date service was provided.
27		SD1	The member's coverage was not in effect on the date service was provided.
27		SM	Coverage is no longer in force.
27		SM1	The member's coverage was not in effect on the date service was provided.

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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	
	<i>Start: 01/01/1995</i>	TF0	Timely-filing not met. Claim submitted after contract time limit.
29		972	Timely- filing not met. Claim submitted after contact time limit.
30	<i>Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.</i>	None	
	<i>Start: 01/01/1995 Stop: 02/01/2006. Replaced by 177,178,179 & 180</i>		
31	Patient cannot be identified as our insured.	None	
31	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	22M	Our records indicate the patient eligibility is under a plan with dental coverage only.
31		872	OEA's records reflect this patient is not covered. Please contact you r school district.
31		S7	Member is over maximum age.
31		S16	No plan selection event plan found
31		S1A	The member's coverage was not in effect on the date service was provided.

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31		S1B	The member's coverage was not in effect on the date service was provided.
31		SB	Member and spouse only coverage.
31		SD	Member and children only coverage.
31		SE	Spouse and child only coverage.
31		SF	Spouse only coverage.
31		SG	Child only coverage.
31		SL	Retirees are not covered.
31		SN	Patient is not eligible for benefits.
31		SP	Eligibility confirmation for this month has not been received.
31		ST	The patient is not eligible.
32	Our records indicate that this dependent is not an eligible dependent as defined.	None	
32	<i>Start: 01/01/1995</i>	871	OEA choice trust shows no proof of dependent status.
32		S6	Dependent is over maximum age.
33	Insured has no dependent coverage.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	SC	Member only coverage.
34	Insured has no coverage for newborns.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
35	Lifetime benefit maximum has been reached.	None	
35	<i>Start: 01/01/1995 Last Modified: 10/31/2002</i>	L2A	Lifetime major medical maximum has been met. No further benefits are available.

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35		L2E	Payment amount has been applied to \$500.00 lifetime maximum benefit.
38	<i>Services not provided or authorized by designated (network/primary care) providers.</i>	None	
	<i>Start: 01/01/1995 Last Modified: 06/02/2013 Stop: 01/01/2013 Replaced by 242 and 243</i>		
39	Services denied at the time authorization/pre-certification was requested.	None	
39	<i>Start: 01/01/1995</i>	043	This Pre-authorization request was denied.
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
40	<i>Start: 01/01/1995 Last Modified: 03/01/2017</i>	M13	Per medical record review, the service does not meet emergency room criteria. Benefit has been made for the assessment fee.
40		M15	Per medical record review, the service does not meet emergency room criteria. No benefits issued.
40		70E	Per review, service do not meet medically necessary emergency care.
42	<i>Charges exceed our fee schedule or maximum allowable amount.</i>	None	

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	<i>Start: 01/01/1995 Last Modified: 10/31/2006 Stop: 06/01/2007</i>		
43	<i>Gramm-Rudman reduction.</i>	<i>None</i>	
	<i>Start: 01/01/1995 Stop: 07/01/2006</i>		
44	Prompt-pay discount.	None	
	<i>Start: 01/01/1995</i>		
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	None	
45	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	002	Increased allowable-provider.
45		003	Reduced allowable-provider.
45		015	Increased allowable amount per unit.
45		017	Increased allowable-units
45		03E	The charge is over the maximum plan allowance for this procedure.
45		03F	The charge is over the maximum plan allowance for this procedure.
45		03M	The charge is over the maximum plan allowance for this procedure.
45		067	Patient liability disallow override.
45		06M	This is the case rate payment
45		103	NDC code priced.

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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		145	PHCS provider discount has been applied.
45		16M	Please resubmit pharmaceutical with valid NDC# and dosage information.
45		39M	Procedure is not included in the provider's contract. Patient not responsible for the balance.
45		401	Community Care Network (CCN) provider discount has been applied.
45		402	Community Care Network (CCN) provider discount has been applied.
45		506	ODS Advantage does not cover this procedure code for women's exams or GYN visits.
45		507	Priced with covered G0101. For reconsideration, please send corrected claim using original medicare's coding guidelines.
45		509	Requested information not received - Provider.
45		526	Coverage based on Medicare allowed amount.
45		528	This procedure is not included in the provider's contract. Patient not responsible for the balance.

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45		529	Your doctor did not accept assignment for this service. Under Federal law, your doctor can not charge more then the patient responsibility
45		530	Diagnosis on claim not covered by Medicare/ODS Advantage. Documentation of prior member notification must be on file before billing member.
45		541	Only in-house staff are approved to perform MTM services under this ODS Advantage plan. Member may not be billed.
45		563	Service/item noncovered by Medicare for the diagnosis. Documentation of prior member notification must be on file before billing member.
45		5M4	This service cannot be paid to this provider type. Not HPSA provider or procedure is statutory exclusion on CMS Physician Fee Schedule.
45		5M5	This service cannot be paid to this provider type. Not HPSA provider or procedure is statutory exclusion on CMS Physician Fee Schedule.
45		70D	Plan only allow up to the normal benefit less the amount paid by the no-fault, liability or workers' compensation carrier.

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45		70K	Charge over the Oregon Surprise Billing allowed amount cannot be balanced billed
45		718	This procedure is not included in the provider's contract. Patient is not responsible for the balance.
45		782	Allowance based on Medicare allowable amount
45		804	This service is not covered. Chart notes have not been received from the dentist to confirm need.
45		83A	The fee charged exceeds the maximum allowance
45		83M	The maximum benefit allowable under this plan is the normal benefit less the amount payable under your primary 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
45		9A1	The fee charge exceed the maximum allowance.
45		9A6	The charge exceeds the Delta amount allowed.

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45		9A8	The charge exceeds the amount allowed.
45		9AN	The fee charge exceed the maximum allowance.
45		9AP	Provider discount has been applied.
45		9B1	Provider discount has been applied.
45		9C1	The fee charged exceeds the maximum allowance.
45		9C6	The charge exceeds the Delta amount allowed
45		9C8	The charge exceeds the amount allowed.
45		D01	Dental allowable-provider.
45		D02	Dental allowable-patient.
45		D12	Decreased Dental allowable amount per unit.
45		D14	Decreased Dental allowable units.
45		D15	Dental Disallow amount.
45		D21	Deny Ortho Tx
45		E8M	Provider discount has been applied.
45		E8N	Provider discount has been applied.
45		GDM	Processed with ODS contract #111.
		GEM	Processed with ODS contract #999.
45		L71	Benefit limit exhausted; service/item noncovered. ODS Advantage requires documentation of prior member notification before billing member.
45		M01	Increased allowable-patient.
45		M02	Reduced allowable-patient.
45		PAA	The charge exceeds the contracted amount for this service.
45		PAC	This is your Per Case rate.

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45		PAF	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
45		PAG	No available APC/Fee schedule rate.
45		PAH	APC Rate.
45		PAK	The charge exceeds the contacted amount for this service.
45		PAL	This is your Per Diem payment.
45		PAP	The charge exceeds the contracted rate for this service.
45		PDA	The charge has been reduced based on a discount arrangement with the provider of service.
45		PDC	Provider discount has been applied.
45		PDD	The charge has been reduced based on a discount arrangement with the provider of service.
45		PDP	The charge has been reduced based on a discount arrangement with the provider of service.
45		PE0	This is your DRG payment.
45		PEO	The charge exceeds the contracted amount for this service.
45		PEX	External pricing disallow.
45		PFC	The charge exceeds the scheduled R & C amount for this procedure.
45		PFS	The charge exceeds the allowable amount for this service.
45		PFU	The charge exceeds the allowable amount for this service.

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45		PFV	The charge exceeds the allowable amount for this service.
45		PFW	The charge exceeds the allowable amount for this service.
45		PGA	The charge exceeds the DRG amount for this confinement.
45		PGD	The charge exceeds the DRG amount for this confinement.
45		PGE	The charge exceeds the DRG rate for this confinement.
45		PGO	The charge exceeds the DRG amount for this confinement.
45		PGP	The charge exceeds the DRG amount for this confinement.
45		PGR	The charge exceeds the DRG amount for this confinement.
45		PMI	Procedure modifier combination invalid or a required modifier is missing.
45		PMP	Price Adjusted Due to Additional Line Item Modifiers.
45		PPC	Exceeds the Ambulatory Payment Classification (APC) rate.
45		PPG	Exceeds APG rate for the line item
45		PSC	The charge exceeds the usual and customary amount for this procedure.
45		PSR	The charge exceeds the allowable rate for this service.
45		TF1	Timely filing not met by the provider. Claim submitted after contract time limit.

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45		TF2	Timely filing not met. Claim submitted after contract limit.
45		TR2	The charge exceeds the covered amount for this service.
45		TR3	allowed amount plus related history amount.
45		W6T	Paid according to your PPO contract with First Choice Network.
45		W7E	Paid according to your PPO contract with First Health Network
45		W7F	First Health Travel Network Automated Pricing attempted in the pre-adjudication process.
45		WGV	The allowed amount for this lab panel code is adjusted due to amount previously allowed for a panel component.
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
50	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	05M	No medical necessity indicated for this service or supply.
50		05R	Benefits previously paid for this supply. No medical necessity indicated for replacement at this time.
50		0M2	Based on Consultant review, medical necessity for the procedure, service or item submitted has not been established.
50		534	Service has been identified as a Never Event and is not eligible for reimbursement.
50		73F	Only initial diagnostic services are covered. Future treatment will be subject to medical necessity.
50		80B	Not medically necessary per Therapeutic Drug Monitoring Criteria.
50		90B	This is not covered. There is no recession or movement of gingival margin.
50		922	Based on consultant review, need was not established. No benefit can be provided.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
50		947	Service has been identified as a Never Event and is not eligible for reimbursement.
50		950	These are non-covered services because this is not deemed a "Medical Necessity" by the payer.
50		9G0	Not Medically Necessary per Therapeutic Drug Monitoring Criteria.
50		N09	The services rendered appear to be cosmetic in nature and not covered under the terms of the plan.
50		Z02	Service was reviewed and determined not to be medically necessary. Services are denied to provider. Do not bill patient.
51	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
51	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
51		906	Pre-existing conditions are not covered.
52	<i>The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.</i>	None	
	<i>Start: 01/01/1995 Stop: 02/01/2006. Replaced by 170, 183, 184 & 185.</i>		
53	Services by an immediate relative or a member of the same household are not covered.	None	
	<i>Start: 01/01/1995</i>		
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
54	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	N06	This procedure does not normally require the services of an assistant surgeon.
54		WGA	The nature of this surgical procedure does not normally require the services of an assistant surgeon.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
55	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	517	Experimental or investigational services and/or supplies are not covered.
55		701	This procedure is considered experimental in nature and not a covered service under the plan
55		9H8	Investigational care costs associated with clinical trial participation are not covered. Service is considered
55		9I1	experimental/investigational and not covered under this plan. Services are denied to provider. Do not bill patient.
55		N10	This procedure is considered experimental in nature and not a covered service under the plan
55		Z01	Service is considered experimental/investigational and not covered under this plan. Services are
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	814	Based on consultant review treatment does not have good long term outcome.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
57	<i>Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.</i>	None	
	<i>Start: 01/01/1995 Stop: 06/30/2007 Split into codes 150, 151, 152, 153 and 154</i>		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>		
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
59	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	048	The allowable amount for this service has been reduced according to ASC multiple procedure guidelines.
59		049	The allowable amount for this service has been reduced according to ASC default category guidelines.
59		056	Allowance reduced based on Multiple Surgery guidelines.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
59		761	Claim review results. Multiple surgery fee reductions apply to this code.
59		9C9	Allowance reduced based on Multiple Surgery guidelines.
59		WGQ	Allowance reduced based on Multiple Surgery guidelines.
59		WGR	Allowance based on bilateral fee adjustment rules.
59		WGS	Procedure not eligible for bilateral fee adjustments; procedure inherently bilateral per Physician Fee Schedule or code definition.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	None	
	<i>Start: 01/01/1995 Last Modified: 06/01/2008</i>		
61	Adjusted for failure to obtain second surgical opinion.	None	
	<i>Start: 01/01/1995 Last Modified: 03/01/2017</i>		
62	<i>Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.</i>	None	
	<i>Start: 01/01/1995 Last Modified: 10/31/2006 Stop: 04/01/2007</i>		
66	Blood deductible.	None	
	<i>Start: 01/01/1995</i>		
69	Day outlier amount.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 01/01/1995</i>		
70	Cost outlier - Adjustment to compensate for additional costs.	None	
	<i>Start: 01/01/1995 Last Modified: 06/30/2001</i>	OUT	Outlier Pricing.
74	Indirect Medical Education Adjustment.	None	
	<i>Start: 01/01/1995</i>		
75	Direct Medical Education Adjustment.	None	
	<i>Start: 01/01/1995</i>		
76	Disproportionate Share Adjustment.	None	
	<i>Start: 01/01/1995</i>		
78	Non-covered days/room charge adjustment.	None	
	<i>Start: 01/01/1995</i>	124	Plan allows up to semi-private room rate.
85	Patient Interest Adjustment (Use Only Group code PR)	None	
	<i>Start: 01/01/1995 Last Modified: 07/09/2007</i>		
87	<i>Transfer amount.</i>	None	
	<i>Start: 01/01/1995 Last Modified: 09/20/2009 Stop: 01/01/2012</i>		
88	<i>Adjustment amount represents collection against receivable created in prior overpayment.</i>	<i>None</i>	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
89	Professional fees removed from charges. <i>Start: 01/01/1995</i>	None	
89		WGZ	This automated lab test is not eligible for separate professional payment.
89		WGz	This automated lab test is not eligible for separate professional payment.
90	Ingredients cost adjustments. Usage: To be used for pharmaceuticals only. <i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	None	
91	Dispensing fee adjustment. <i>Start: 01/01/1995</i>	None	
94	Processed in Excess of charges.	None	
94	<i>Start: 01/01/1995</i>	PAI	The charge exceeds the contracted amount for this service.
94		PAR	The charge exceeds the contracted amount for this service.
95	Plan procedures not followed. <i>Start: 01/01/1995 Last Modified: 09/30/2007</i>	None	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	03D	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
96		044	This request for a referral was denied.
96		065	This is not a covered HRA service.
96		066	Not covered under Medical Plan--to be paid as 'HRA Only' service.
96		068	No Pledge Amount for this HealthCare Expense.
96		069	No Pledge Amount for the Dependent Care Expense.
96		073	Deny All Claim Lines.
96		122	The plan allows preventive health care benefits only when services are provided by the Primary Care Physician (PCP).
96		141	The service is not covered. Our records indicate another provider is the primary chemical dependency provider for this service.
96		144	The diagnosis and treatment pair is below the line as defined on the prioritized list of covered services.
96		170	Services received within 60 days from the last service are not covered. Please check you records.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		513	Service/item noncovered by CMS and ODS Medicare Advantage. Documentation of prior member notification must be on file before billing member.
96		520	Service not covered. The provider has chosen (opted out) or is not allowed (sanctioned) to bill Medicare for services/test/supplies.
96		523	The covered portion of this item/service is billed under another code. This portion/upgrade feature is not covered under your plan.
96		525	The services provided to you in a Veterans Affairs (VA) facility are not covered by ODS Advantage because criteria listed in Evidence of Cov.
96		581	Medicare does not pay for this equipment, item, or service. Provider indicates member was informed in writing that this was not covered.
96		582	Denied because Medicare only covers this under certain circumstances. Claim indicates member was informed in writing this was not covered.
96		70A	Claim processed for encounter purposes only. This provider is not part of the ODS network.
96		73B	The total billed units for this procedure are medically unlikely.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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		750	This service is not covered. The attending dentist does not participate in the ODS/Oregon Health Plan.
96		809	Benefit is provided for fluoride once every six months up through the age of 18.
96		80C	This service is not covered. The buildup on this tooth is not covered because the final restoration is not covered.
96		80E	This kind of medicine is not covered.
96		80P	Based on our contract with Lane County this service is not covered. This member has a primary care dentist.
96		810	Benefit is provided for examination, bitewing x-rays and one prophylaxis (including scaling and curettage) in each six month period.
96		811	Payment is provided for a complete series x-rays (including panoramic) once in a three year period.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		812	Payment for an examination fee includes the use of diagnostic aids, except for x-rays, study models and certain lab test.
96		813	Payment is provided for study models for cases involving three or more missing teeth (not full dentures). Limited to one every five years.
96		816	Payment is provided for a single surface restoration in each episode of treatment regardless of the number of restorations placed.
96		831	No payment is provided for fixed bridges or removable cast partials for patients under the age of 16.
96		832	Payment is provided for stayplates, temporary partials, or temporary bridges only to replace recently extracted anterior teeth.
96		835	Based on our records this tooth is missing.
96		83D	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
96		841	Payment is provided for fixed bridge abutment restorations as part of the prosthetic benefit regardless of the condition of the abut. Teeth

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		856	Payment is provided for general anesthesia only in conjunction with covered surgical procedures performed in a dental office.
96		85A	Sealant repairs are not covered.
96		865	Payment is not provided for hospitalization, including hospital visits and procedures.
96		868	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
96		870	Payment is not provided for incomplete treatment. Please file on the completion date.
96		882	Appliances, restorations or procedures are not payable when done to increase vertical dimension.
96		885	Appliances, restorations or procedures are not payable when done to realign teeth.
96		886	Appliances, restorations or procedures are not payable when done to treat disturbances of the TMJ and associated structures.
96		887	Appliances, restorations or procedures are not payable when done for cosmetic reasons.
96		890	Appliances, restorations or procedures are not payable when done to correct habits.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		8C3	This is not covered. Replacing a space maintainer is not covered.
96		8D5	Service is not covered on this tooth.
96		924	Based on our records this tooth is missing.
96		926	The root canal on this tooth is not covered because the final repair is not covered.
96		959	Procedure is not covered for this tooth.
96		976	Implants are not covered. Implants may be covered by a separate plan offered through ILWU-PMA Benefit Plans. For details call 415-673-8500.
96		998	Temporary treatment not covered.
96		9AQ	Non Covered. Modifier GA/GX indicates you prior-informed member in writing services would not be covered & member signed agreement to pay.
96		9B0	This is not covered. Teeth were pulled more than 6 months ago.
96		9C0	Not a covered service. Our records show there are not enough missing teeth.
96		9G8	Specialized and experimental techniques or precision attachments are not covered.
96		9H1	Retainer adjustments are considered part of the initial treatment. Benefits are not covered.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		9H5	Self-administered medications are excluded when not provided by a pharmacy; covered only through the prescription medication benefits.
96		9H6	Self-administered medications are excluded when not provided by a pharmacy; covered only through the prescription medication benefits.
96		9H9	Statutorily non-covered. Medicare does not pay for this item or service.
96		9I2	Statutorily non-covered. Medicare does not pay for this item or service.
96		A00	Services provided are not a covered benefit with ODS Advantage.
96		DP1	Procedure is not covered for this tooth.
96		E05	Payment is provided only for charges by a licensed dentist.
96		E68	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
96		E98	OHP Prioritized List-Matched by Dx Only
96		MLN	Please submit the primary diagnosis.
96		PS0	This service is not covered under the plan.
96		PS3	Non-covered benefit. Non-participating provider.
96		TR1	This is not a covered service under the plan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
96		Z06	Determined to be a contract exclusion. Services are denied to provider. Do not bill patient.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
97	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	2M0	Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service.
97		503	No separate payment can be made for this service. This is a Medicare bundled/excluded code.
97		512	This service or supply is included in the payment for another service.
97		706	Time documented is less than eight minutes. Service is not separately reimbursable. Does not meet requirements of 8-minute rule.
97		707	Benefits for miscellaneous charges are included in the payment for the base rate.
97		709	Audit results. This service is a component of a more comprehensive and/or global service and should not be reported separately.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		711	This service is not eligible on the day of discharge.
97		721	The surfaces must be combined and billed, one line per tooth, using appropriate code.
97		73C	Service denied because billed outside of the time-frame requirements for a similar or related service already allowed.
97		752	Claim review results. This item not eligible to be separately reported or never eligible for separate reimbursement
97		753	Claim review results. The payment for this service is included in the fee for one of the other services already allowed.
97		754	Claim review results. This service is always included in another service already allowed. This edit is never eligible for a modifier bypass.
97		755	Review results. Requirements for separate and distinct service allowance and/or modifier not met. Included in allowance for another service.
97		771	Claim review results. Item(s)/services identified as not eligible to be separately reported or never eligible for separate reimbursement.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		773	Review results. Documentation does not support modifier 58/79. Service determined to be related to previous surgery & allowance reduced.
97		774	Claim review results. Service has been determined to be part of the Global Surgical Package. No separate reimbursement can be made.
97		77M	Benefits for miscellaneous charges are included in the payment for the base rate.
97		788	Review. Outpatient services related to inpatient services; not separately billable. Charges are included in inpatient reimbursement.
97		789	Review. Readmission within set time frame from discharge may not be billed separately. Included in Inpatient reimbursement.
97		7C8	DRG review using the readmission claim information has reassigned the DRG on the combined claims.
97		802	Retreatment of root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment fee.
97		806	This service is included in other services on this claim, treatment date or tooth.
97		807	Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		80J	This service is not covered. Adjustments and repairs to dentures are not covered within 6 months of receiving the denture.
97		80K	A separate payment is not provided for dental surgery that shapes the bone that supports the teeth in conjunction with removal of teeth.
97		80L	A separate payment is not provided for dental surgery that shapes the bone that supports the teeth in conjunction with removal of teeth.
97		80N	This service or supply is included in the payment for another service.
97		80Q	Benefit limited within 6 months.
97		819	Preparation of gingival tissue for placing a restoration should be included in the fee for the restoration.
97		81G	The fee for this service is included in the fee for the exam.
97		81P	This service is not covered. Adjustments and repairs to dentures are not covered within 6 months of receiving the denture.
97		820	A separate, additional payment is not provided for tooth preparation, temporary treatment, bases, impressions or local anesthesia.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		821	Payment is provided for pulp capping when there is exposure of the pulp. We do not predetermine this expense.
97		82E	Full series x-rays and single x-rays billed on the same day are considered a complete series.
97		82F	A Build-Up is only a benefit when needed to hold a crown in place.
97		82G	A build up is part of a build up post.
97		82H	More than one deep cleaning done on the same day and in the same area is reimbursed as one cleaning.
97		82I	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		82J	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		82K	More than one deep cleaning done on the same day and in the same area is reimbursed as one cleaning.
97		82L	This gum treatment is included in other gum treatment in the same area.
97		82M	This gum treatment is included in other gum treatment in the same area
97		82N	Full series x-rays and single x-rays billed on the same day are considered a complete series.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		82O	Cone beam capture is included in the fee for taking and reading the image.
97		82P	MRI capture is included in the fee for taking and reading of the image
97		82Q	The charge for the ultrasound is part of the fee for taking and reading the image.
97		82R	Reading an image is part of the fee for taking and reading the image.
97		82T	Full series x-rays and single x-rays billed within 60 days are considered a complete series.
97		82U	Full series x-rays and single x-rays billed within 60 days are considered a complete series.
97		837	Reline is included in the amount of payment provided for the complete replacement of a denture base (jump) fee.
97		83E	Charges to remove tissue from around the tooth is limited to once for the same space.
97		83F	Charges to remove tissue from around the tooth is limited to once for the same space.
97		83G	Closing the hole in the sinus is part of the surgical extraction.
97		83H	Closing the hole in the sinus is part of the surgical extraction.
97		83I	A biopsy done at the same time as surgery is part of the surgery.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		83J	A follow up cleaning for the gums includes deep cleaning of the entire mouth on the same day.
97		83K	This gum treatment is included in other gum treatment in the same area
97		83L	Deep cleaning below the gums done twice in the same area is combined to one deep cleaning.
97		847	This service is not covered. Denture adjustments or follow up care is not covered if done within 6 months of the initial treatment.
97		84N	A build-up is only a benefit when needed to hold a crown in place.
97		84O	A build-up is part of a build-up with a post.
97		84P	A build-up is part of a build-up with a post.
97		84Q	Benefit for this procedure is limited to one time per day per tooth.
97		84R	Benefit for pin retention is limited to one time per day per tooth.
97		84S	Benefit for pin retention is limited to one time per day per tooth.
97		84T	Pins are part of the Build-Up.
97		84U	The removal of a post from this tooth is part of the root canal retreatment.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		84V	The removal of a post from this tooth is part of the root canal retreatment.
97		84W	A new crown under a partial is part of the benefit for the partial.
97		84X	A new crown under a partial is part of the benefit for the partial.
97		851	This service not covered. Replacement is limited to one time every 24 months. This is part of the initial service.
97		853	Recementation of restorations performed within six months of initial placement is considered part of the initial placement fee.
97		867	A separate, additional payment is not provided for alveoloplasty done in conjunction with the surgical removal of teeth.
97		891	Benefits limited to once per orthodontic case.
97		8A1	This services is not covered. Replacement of crown is not covered if performed within twenty four months of the 1st placement.
97		8A2	Replacement of an amalgam or composite restoration is not covered if performed within twelve months of the initial placement.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		8A4	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.
97		8A8	A separate, additional payment is not provided for repair or relines done within six months after initial placement of occlusal guard.
97		8A9	Retreatment of root canal or apical surgery performed within 12 months of initial treatment is considered part of the initial treatment fee.
97		8B1	This services is not covered. Replacement of a filling is not covered if performed within twelve months of the initial placement.
97		8B2	This service is not covered. Replacement of a filling is not covered when done within 24 months of the first placement.
97		900	Benefits limited to once per orthodontic case.
97		905	This predetermination is valid only when the complete denture is placed within 6 months of the extraction(s) in the same arch.
97		917	Retreatment of root canal or apical surgery performed within 6 months of initial treatments is considered part of the initial treatment fee.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		919	This service is not covered. Denture adjustments or follow up care is not covered if done within 6 months of the initial treatment.
97		921	This service is included in other services on this claim, treatment date or tooth.
97		927	This service is not covered. Based on consultant review, need was not established. Treatment is considered part of the restoration.
97		929	This service is limited. We are allowing this as a different service.
97		930	Based on Consultant review, benefit has been changed.
97		949	A separate, additional payment is not provided for Alveoloplasty in conjunction with surgical removal of teeth.
97		956	A separate additional payment is not provided for reading of Xrays.
97		957	Invisalign is considered cosmetic. Benefit is limited.
97		958	Invisalign is considered cosmetic. Benefit is limited.
97		960	A separate additional payment is not provided for reading of Xrays.
97		969	Post-operative visits are considered a part of the complete procedure. No extra payment is provided.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		979	Reattachment of a tooth fragment is not covered if done within 24 months of an amalgam or composite restoration or reattachment.
97		993	A separate, additional payment is not provided for denture adjustment and post-op care done within six months after initial placement.
97		994	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.
97		995	Included in orthodontic treatment fee
97		996	Replacement of restoration is not covered if performed withing twenty four months of the initial restoration
97		997	Payment is included in the allowance for another service/procedure.
97		9E9	Crown lengthening is included in the fee for the restoration.
97		9F1	Procedure is included in final restoration.
97		9F9	Fees for all x-rays have been given an alternate benefit of a full mouth x-ray.
97		9G1	The fee for this service is included in the fee for the anesthesia.
97		9G2	Retreatment of root canal or apical surgery performed within 12 months of initial treatment is considered part of the initial treatment fee

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		9G6	Benefit Limited Within 6 Months
97		9G9	Retainer adjustments are considered part of the initial treatment fee. Additional benefit is not provided.
97		9H0	Repairs done within 24 months of the initial placement are considered part of the initial restoration fee.
97		DP3	Allowable benefit has been reduced to the plan allowed amount for this service(s).
97		N01	The charges for this procedure have been considered as part of another more comprehensive procedure code.
97		N02	This procedure is considered redundant to another billed procedure code.
97		N03	This procedure is considered secondary to the primary procedure.
97		N04	This service is considered a part of the original surgical procedure.
97		N05	This service is not covered when performed on the same day as a surgical procedure.
97		N25	The charges for this service have been combined into the primary procedure.
97		N31	The charges for this procedure have been combined with those of the primary procedure.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		N32	The charges for this procedure have been combined with those of the primary procedure.
97		N50	Current procedure rebundle.
97		N51	History procedure rebundle.
97		N52	Duplicate unilateral or bilateral procedure.
97		N53	Duplicate history unilateral or bilateral procedure.
97		N56	Duplicate procedure submitted.
97		N57	History duplicate procedure submitted.
97		N58	History Mutually Exclusive Procedure
97		N59	History incidental procedure.
97		N65	History post-OP conflict within 90 days.
97		SQ1	Patient no longer eligible.
97		WGB	Service is considered included in the payment for another more comprehensive procedure code.
97		WGC	Multiple CPT codes have been combined into one code that describes all the services.
97		WGD	This service or physician visit is considered part of the global surgical package. No separate reimbursement is available.
97		WGE	Service is included in the payment for the physician visit code.
97		WGF	Only one visit/evaluation and management code is allowed per date of service.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		WGG	Payment for immunizations includes payment for the injection.
97		WGH	Payment for lab services include blood drawing and/or specimen collection fees.
97		WGI	Procedure code billed more than once for the same day, and appears to be a duplicate billing for the same service.
97		WGL	This procedure code is only eligible to be billed once per day. Additional units for the same day are included.
97		WGM	Service denied because payment already made for the same or similar procedure within the defined time frame.
97		WGN	This procedure code is only eligible to be billed once per week.
97		WGO	This service or supply is included in the payment for another service.
97		WGP	Service is considered a mutually exclusive procedure to another code billed. If required, modifier may not be present/correctly used.
97		WGT	Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.
97		WGt	Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
97		WGU	NCCI always disallows this procedure when billed with another procedure billed on this DOS. This edit is not eligible for a modifier bypass.
97		WHA	This service is included in the global obstetric care service and should not be reported separately.
97		WHB	The allowed amount for this global OB code is adjusted due to previously allowed antepartum care.
97		WHF	This service (antepartum, delivery, postpartum, global maternity) may only be billed once per pregnancy. Redundant to another billed code.
97		WHG	Service denied because billed outside of the time-frame requirements for a similar or related service already allowed.
97		Z07	Not paid to provider when provided to patient in this place of service. Payment included in the reimbursement to the facility.
97		Z08	Not paid to provider when provided to patient in this place of service. Payment included in the reimbursement to the facility.
100	Payment made to patient/insured/responsible party/employer. Effective 05/01/2018: Payment made to patient/insured/responsible party.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 01/01/1995 Last Modified: 11/01/2017</i>		
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	None	
101	<i>Start: 01/01/1995 Last Modified: 02/28/1999</i>	909	Treatment plan 1.
101		910	Treatment plan 2.
102	Major Medical Adjustment.	None	
	<i>Start: 01/01/1995</i>	PBM	Major Medical Benefits Applied.
103	Provider promotional discount (i.e. Senior citizen discount).	None	
	<i>Start: 01/01/1995 Last Modified: 06/30/2001</i>		
104	Managed care withholding.	None	
	<i>Start: 01/01/1995</i>		
105	Tax withholding.	None	
	<i>Start: 01/01/1995</i>		
106	Patient payment option/election not in effect.	None	
	<i>Start: 01/01/1995</i>		
107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
107	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	5M1	Denied for criteria not met; another specific code (item/service/drug/medication) must also be billed on the same day.
107		765	Review result. Add-on code violation. The required primary code for this service has not been billed or has been denied in the audit.
107		WGJ	The procedure (add-on) code is not allowed separately. The required primary code was not billed for the same date of service.
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
108	<i>Start: 01/01/1995 Last Modified: 07/01/2017</i>	89M	The plan covers rental (not to exceed the reasonable purchase price) of medically necessary durable medical equipment.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	None	
109	<i>Active: 1/1/95 Last Modified: 01/29/2012</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
109		40E	Provider is requested to submit claim to Valueoptions: PO Box 1290, Lathan, NY 12110. For more information call 1-800-892-8804.
109		450	Not covered under the dental plan. Service may be eligible for reimbursement under the member's Health Reimbursement Account.
109		508	Part D service. Please bill patient.
109		931	Hospice services need to be billed directly to Original Medicare. Please rebill to the correct carrier.
109		S5	Member has no coverage for this date of service or benefit type.
110	Billing date predates service date.	None	
	<i>Start: 01/01/1995</i>		
111	Not covered unless the provider accepts assignment.	None	
	<i>Start: 01/01/1995</i>		
112	Service not furnished directly to the patient and/or not documented.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
113	<i>Payment denied because service/procedure was provided outside the United States or as a result of war.</i>	None	
	<i>Start: 01/01/1995 Last Modified: 02/28/2001 Stop: 06/30/2007 Replaced by 157, 158 or 159.</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
114	Procedure/product not approved by the Food and Drug Administration.	None	
	<i>Start: 01/01/1995</i>	585	The NDC submitted is not FDA approved for the date of service.
115	Procedure postponed, canceled or delayed.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
116	The advance indemnification notice signed by the patient did not comply with requirements.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
117	Transportation is only covered to the closest facility that can provide the necessary care.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
118	ESRD network support adjustment.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
119	Benefit maximum for this time period or occurrence has been reached.	None	
119	<i>Start: 01/01/1995 Last Modified: 02/29/2004</i>	062	All FSA dollars were previously paid out.
119		13D	Benefit of one such service per day. Type of service was exhausted on earlier claim for the same date of service.
119		13M	Benefit is limited to one time per 12 months.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 prenatal/child birthing classes has been met. Patient responsibility applied.
119		45M	Inpatient maximum for this condition has been reached.
119		79M	Maximum benefit has been reached for this type of service.
119		80O	This is not covered. Removable partial Dentures are only covered once in a five year period.
119		80S	Limited to once in a three month period.
119		81B	Limited to Once in a Six Month Period.
119		822	Payment is provided for cast restorations, porcelain crowns, and/or a prosthetic device once in a four year period.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		824	Payment is provided for a full mouth x-ray (including panographic) once in a two year period.
119		825	Payment is provided for a full mouth x-ray (including panographic) once a year.
119		827	Payment is provided for cast restorations and porcelain crowns once in a three year period.
119		828	Payment is provided for one periodontal recall visit once in a three month period.
119		829	This service is not covered. Benefit for a cast restoration, crown, or prosthetic device is covered one time per five years.
119		82A	Limited to once every two years.
119		82S	Assessments are limited to once in any 12 month period.
119		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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	This is not covered. Removable or complete Dentures are only covered once in a ten year period.
119		860	Benefit is provided for topical fluoride once in each six month period.
119		8B3	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a 36 month period.
119		8B4	Limited to once in a five year period.
119		8B5	This service is not covered. Payment for dentures is covered once every 10 years.
119		8B6	Orthodontic records including Models and Photographs are a benefit once in a five year period and limited to a \$35.00 maximum.
119		8B7	Benefit is limited to Ten (10) in a Twelve (12) month period.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		8B8	This is not covered. Removable partial Dentures are only covered once in a five year period.
119		8B9	This is not covered. Replacement of partial Dentures with full dentures are only covered once in a five year period.
119		8C1	Limited to ten services in a three month period.
119		8C2	Limited to once per tooth in five years.
119		8C4	Permanent crowns are limited to four in a seven year period.
119		8C5	Limited to once per tooth per lifetime.
119		8C6	Limited to once in a three year period.
119		8C7	Limited to once every two years.
119		8C8	Limited to once in a six month period.
119		8C9	Limited to once in a ten year period.
119		8D1	Service limited to one time in a lifetime
119		8D2	Limited to once per denture.
119		8D3	Limited to once per visit.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		8D4	Limited to four per year.
119		8D6	Benefit is limited to ten (10) in a three (3) month period.
119		8D8	Limited to once every two years.
119		903	The maximum allowed for this type of service has been reached.
119		925	The maximum allowed for this type of service has been reached.
		952	Benefit limited to once in a lifetime.
119		953	Benefit is Limited to two (2) times per year.
119		955	Implant maximum has been met for this benefit year.
119		971	Emergency services performed by an out of network provider are limited to a \$100.00 maximum benefit.
119		977	Limited to once per tooth in five years.
119		981	Cleaning and inspection of a removable appliance are limited to once per year
119		982	Assessment are limited to 2 in a 12 month period.
119		984	Assessment are limited to once in any 12 month period.
119		9A2	Benefit is 2 prophys per 12 month period. This prophy is the last payment for the benefit period; or, the maximum allowed has been reached.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		9A3	Benefit is 2 fluoride per 12 month period. This fluoride is the last payment for the benefit period or the maximum allowed has been reached.
119		9A4	The maximum allowed for services of this type has been reached.
119		9A5	The maximum allowed for services of this type has been reached.
119		9B2	Orthodontia services are not covered due to patient's age
119		9B6	Based on review, need was not established. No benefit can be provided.
119		9D0	Complete dentures are covered only one time.
119		9D2	Orthodontic service maximum has been met for this benefit period.
119		9F7	Permanent crowns are limited to four in a seven year period.
119		9F8	Limited to once in a three year period.
119		9H7	No more than two quadrants allowed on the same date of service
119		CG3	Maximum has been met for these services.
119		DP2	The maximum allowed for this type of service has been reached.
119		L09	Class III maximum benefit has been met for this benefit year.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		L10	Maximum has been met for these services. No further benefits are available.
119		L11	The maximum has been met for durable medical equipment and/or supplies.
119		L13	Preventive health care maximum has been met for this benefit period.
119		L14	Vision service maximum has been met for this benefit period.
119		L15	Chiropractic service maximum has been met for this benefit period.
119		L16	Naturopathic service maximum has been met for this benefit period.
119		L17	Acupuncture service maximum has been met for this benefit period.
119		L18	Alternative care service maximum has been met for this benefit period.
119		L19	Rehabilitation service maximum has been met for this benefit period.
119		L1A	The yearly stoploss has been met. Benefits will be paid at 100% for the remainder of this calendar/plan year.
119		L20	Audio service maximum has been met for this benefit period.
119		L25	Maximum benefit has been met for this benefit year.
119		L26	Orthodontic maximum has been met for this benefit year.
119		L27	TMJ maximum has been met for this benefit year.
119		L28	Periodontal maximum has been met for this benefit year.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		L52	Medical Prescription service maximum has been met for this benefit period
119		L53	Mental Health and chemical dependency combined counter maximum has been met.
119		L54	Sports Therapy service maximum has been met for this benefit period.
119		L55	Hearing Aid maximum has been met for this benefit period.
119		L56	Hearing exam service maximum has been met for this benefit period.
119		L57	Extended care service maximum has been met for this benefit period.
119		L58	Home health service maximum has been met for this benefit period.
119		L59	Well baby exam maximum has been met for this benefit period.
119		L5A	Prescription self-injectables annual maximum has been met.
119		L5B	Ambulance service maximum has been met for this benefit period.
119		L5D	Skilled nursing facility maximum has been met for this benefit period.
119		L5E	Acupuncture, naturopath and/or licensed massage therapist service maximum has been met for this benefit period.
119		L5F	Well child exam maximum has been met for this benefit period.
119		L60	Individual medical out of pocket maximum has been met.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
119		L61	Family medical out of pocket maximum has been met.
119		L62	Individual medical out of network out of pocket maximum has been met.
119		L63	Family medical out of network out of pocket maximum has been met.
119		L64	Individual hospital out of pocket maximum has been met.
119		L65	Family hospital out of pocket maximum has been met.
119		L66	Individual hospital out of network out of pocket maximum has been met.
119		L67	Family hospital out of network out of pocket maximum has been met.
119		L68	Individual medical out of pocket maximum has been met for PCP level.
119		L69	Family medical out of pocket maximum has been met for PCP level.
119		L70	This service limited to one plan per year. Maximum has been met for this benefit period.
119		L72	State mandated hearing aid maximum has been met for this benefit period
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	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 01/01/1995 Stop: 06/30/2007 Use code 24</i>		
121	Indemnification adjustment - compensation for outstanding member responsibility.	None	
	<i>Start: 01/01/1995 Last Modified: 09/30/2007</i>		
122	Psychiatric reduction.	None	
	<i>Start: 01/01/1995</i>		
<i>123</i>	<i>Payer refund due to overpayment.</i>	None	
	<i>Active: 1/1/95 Deactivate: 6/30/07</i>		
<i>124</i>	<i>Payer refund amount - not our patient.</i>	None	
	<i>Active: 1/1/95 Last Modified: 6/30/99 Deactivate: 6/30/07</i>		
<i>125</i>	<i>Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code)</i>	None	
	<i>Active: 1/1/95 Modified: 6/30/06, 09/30/07 Deactivated: 11/1/2013</i>		
<i>126</i>	<i>Deductible -- Major Medical</i>	None	
	<i>Active: 2/28/97 Deactivated: 4/1/2008</i>		
<i>127</i>	<i>Coinsurance -- Major Medical</i>	None	
	<i>Active: 2/28/97 Deactivated: 4/1/2008</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
128	Newborn's services are covered in the mother's Allowance. <i>Start: 02/28/1997</i>	None	
129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) <i>Start: 02/28/1997 Last Modified: 01/30/2011</i>	None	
130	Claim submission fee. <i>Start: 02/28/1997 Last Modified: 06/30/2001</i>	None 803	A separate fee for completion of a claim form is not covered.
131	Claim specific negotiated discount. <i>Start: 02/28/1997</i>	None 120	The allowance was based on a negotiated rate. The patient is not responsible for the discounted amount.
131		73A	Paid according to your PPO contract with CoreChoice
131		7A6	Paid according to your PPO contract with PHS. For contact disputes please call 866.295.0770.
131		7A7	Paid according to your PPO contract with PHS+. For contract disputes please call 866.295.0770.
131		7A8	Paid according to your PPO contract with PHS (IHP). For contract disputes please call 866.295.0770.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		7A9	Paid according to your PPO contract with PHS (PREVEA). For contract disputes please call 866.295.0770.
131		7B0	Paid according to your PPO contract with PHS (AMCO). For disputes please call 866.295.0770.
131		7B1	Paid according to your PPO contract with PHS (VHN). For contract disputes please call 866.295.0770.
131		7B2	Paid according to your PPO contract with PHS (ACTIVE HC). For contract disputes please call 866.295.0770.
131		7B3	Paid according to your PPO contract with PHS (WRHN). For contract disputes please call 866.295.0770.
131		7B4	Paid according to your PPO contract with PHS (NMG). For contract disputes please call 866.295.0770.
131		7B5	Paid according to your PPO contract with PHS (GHCS). For contract disputes please call 866.295.0770.
131		7B6	Paid according to your PPO contract with PHS (LABNET). For contract disputes please call 866.295.0770.
131		7B7	Paid according to your PPO contract with PHS (BELLINHEALTH_&_THEDACARE). For contract disputes please call 866.295.0770.
131		7B8	Paid according to your PPO contract with PHS (EMPOWERCHIRO). For contract disputes please call 866.295.0770.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		7B9	Paid according to your PPO contract with PHS (CMN). For contract disputes please call 866.295.0770.
131		7C0	Paid according to your PPO contract with PHS-BMI. For disputes please call 866.295.0770.
131		7C1	Paid according to your PPO contract with PHS (VHS-LINK). For contract disputes please call 866.295.0770.
131		7C2	Paid according to your PPO contract with PHS (CCHN). For contract disputes please call 866.295.0770.
131		7C3	Paid according to your PPO contract with PHS (BEHAVIORAL HLTH PROVIDERS) contract. For contract disputes please call 866.295.0770.
131		7C4	Paid according to your PPO contract with PHS (FULCRUM HEALTH). For contract disputes please call 866.295.0770.
131		7C5	Paid according to your PPO contract with PHS (CHIRO MGMT SVCS). For contract disputes please call 866.295.0770.
131		7C6	Paid according to your PPO contract with PHS (YHN). For contract disputes please call 866.295.0770.
131		7C7	Paid according to your PPO contract with PHS (EQUIAN). For contract disputes please call 866.295.0770.
131		80F	Negotiated provider discount has been applied.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		E60	Paid according to Interlink Health Services contract.
131		E61	Paid according to LifeTrac pricing contract.
131		EDM	Processed with Moda Health contract #111.
131		W01	Paid according to your PPO contract with NPPN/PIPA.
131		W02	Paid according to your PPO contract with NPPN/Family Chiropractic America.
131		W03	Paid according to your PPO contract with NPPN/Carrington International Group.
131		W04	Paid according to your PPO contract with NPPN/PPOIN.
131		W05	Paid according to your PPO contract with NPPN/OHIO Preferred Network.
131		W06	Paid according to your PPO contract with HealthSmart/HPO
131		W07	Paid according to your PPO contract with NPPN/Beltone.
131		W08	Paid according to your PPO contract with NPPN/Dahlberg Miracle Ear.
131		W09	Paid according to your PPO contract with NPPN/First Choice Healthplan of MS.
131		W10	Paid according to your PPO contract with NPPN/PPOKY.
131		W11	Paid according to your PPO contract with NPPN/CHN/CT.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W12	Paid according to your PPO contract with NPPN/HCN - WI/Multiplan.
131		W13	Paid according to your PPO contract with NPPN/First Choice Network.
131		W14	Paid according to your PPO contract with NPPN/Select PPO.
131		W15	Paid according to your PPO contract with NPPN/HCVM.
131		W16	Paid according to your PPO contract with NPPN/AHI/Healthlink.
131		W17	Paid according to your PPO contract with NPPN/Physicians Network.
131		W18	Paid according to your PPO contract with NPPN/Henry Ford Health System.
131		W19	Paid according to your PPO contract with NPPN/FCM.
131		W1A	Paid according to your PPO contract with NPPN/HPO/LTD.
131		W1B	Paid according to your PPO contract with NPPN/HPO/MHN.
131		W1C	Paid according to your PPO contract with NPPN/HPO/MMP.
131		W1D	Paid according to your PPO contract with HealthSmart/HPO
131		W1E	Paid according to your PPO contract with TRPN/ACS.
131		W1F	Paid according to your PPO contract with TRPN/Buckeye Network.
131		W1G	Paid according to your PPO contract with TRPN/CMN.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W1U	Paid according to your PPO contract with NPPN/TRPN/Quality Partnership.
131		W1V	Paid according to your PPO contract with Medical Resource 800.543.5260.
131		W1W	Paid according to your PPO contract with MR/American Care Source
131		W1X	Paid according to your PPO contract with MR/American Health Resources Network.
131		W1Y	Paid according to your PPO contract with MR/California Foundation for Medical Care.
131		W1Z	Paid according to your PPO contract with MR/National Hospital Network.
131		W20	Paid according to your PPO contract with NPPN/ABPA/ProHealth.
131		W21	Paid according to your PPO contract with NPPN/HPO/IHP.
131		W23	Paid according to your PPO contract with NPPN/Intergroup.
131		W24	Paid according to your PPO contract with NPPN/Community Health Partners.
131		W25	Paid according to your PPO contract with NPPN/Association of Primary Care Physicians.
131		W26	Paid according to your PPO contract with NPPN/Columbia HCA North Texas Division.
131		W27	Paid according to your PPO contract with NPPN/Universal/NV.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W2N	Paid according to your PPO contract with TRPN/Fortified Provider Network.
131		W2O	Paid according to your PPO contract with TRPN/HFN.
131		W2P	Paid according to your PPO contract with TRPN/Integrated Health Plan.
131		W2Q	Paid according to your PPO contract with TRPN/Managed Care Strategies.
131		W2R	Paid according to your PPO contract with TRPN/National Provider Network.
131		W2S	Paid according to your PPO contract with TRPN/Ohio Preferred Network.
131		W2T	Paid according to your PPO contract with TRPN/Preferred Mental Health Network.
131		W2U	Paid according to your PPO contract with TRPN/Prime Health Services.
131		W2V	Paid according to your PPO contract with TRPN/Quality Healthcare Partnership.
131		W2W	Paid according to your PPO contract with TRPN/Universal Health Network..
131		W2X	Paid according to your PPO contract with Three Rivers Provider Network (TRPN).
131		W2Y	Paid according to your PPO contract with TRPN/Initial Group.
131		W2Z	Paid according to your PPO contract with TRPN/FCHN.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W30	Paid according to your PPO contract with NPPN/Healthcare Network of America.
131		W31	Paid according to your PPO contract with NPPN/PCC PPO.
131		W32	Paid according to your PPO contract with NPPN/MRI.
131		W33	Paid according to your PPO contract with NPPN/MRI/National Hospital Network.
131		W34	Paid according to your PPO contract with NPPN/MRI/National Provider Network.
131		W35	Paid according to your PPO contract with Provider Select (PSI).
131		W36	Paid according to your PPO contract with NPPN/MRI/Galaxy Health Network.
131		W37	Paid according to your PPO contract with NPPN/Health Management.
131		W38	Paid according to your PPO contract with NPPN/Rural Arizona.
131		W39	Paid according to your PPO contract with NPPN/Arizona Medical Network.
131		W3A	Paid according to your PPO contract with NPPN/TRPN/Premium Health.
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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W3E	Paid according to your PPO contract with MR/Fortified Provider Network.
131		W3F	Paid according to your PPO contract with MR/HPO/IHP.
131		W3G	Paid according to your PPO contract with MR/HPO/MHN.
131		W3H	Paid according to your PPO contract with MR/HPO/MMPP.
131		W3I	Paid according to your PPO contract with NPPN/Preferred Mental Health Network.
131		W3J	Paid according to your PPO contract with Beech Street Supplemental Network.
131		W3K	Paid according to your PPO contract with NPPN/Medlink Health Network.
131		W3L	Paid according to your PPO contract with NPPN/Fortified Provider Network.
131		W3M	Paid according to your PPO contract with NPPN/MRI/NPN/Premier Care.
131		W3N	Paid according to your PPO contract with NPPN/MRI/NPN/Medical Network of Colorado Springs.
131		W3O	Paid according to your PPO contract with NPPN/Interplan/TX.
131		W3P	Paid according to your PPO contract with NPPN/Baptist Health Services Group.
131		W3Q	Paid according to your PPO contract with NPPN/Lee Physician Hospital Organization.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W3R	Paid according to your PPO contract with NPPN/Medical Care Referral Group.
131		W3S	Paid according to your PPO contract with NPPN/MRI/Prime Health Service.
131		W3T	Paid according to your PPO contract with MR/Medical Care Referral Group (MCRG).
131		W3U	Paid according to your PPO contract with Healthsmart HPO/Arizona Medical Network.
131		W3V	Paid according to your PPO contract with Healthsmart HPO/Health Management Network.
131		W3W	Paid according to your PPO contract with Interplan Health Group/ Health Payors Organization.
131		W3X	Paid according to your PPO contract with Healthsmart/HPO.
131		W3Y	Paid according to your PPO contract with HealthSmart HPO/Integrated Health Plan.
131		W3Z	Paid according to your PPO contract with HealthSmart/HPO
131		W40	Paid according to your PPO contract with NPPN/Novanet.
131		W41	Paid according to your PPO contract with NPPN/Mayan PPO.
131		W42	Paid according to your PPO contract with NPPN/Healthpoint.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W43	Paid according to your PPO contract with NPPN/Susquehanna Health Care.
131		W44	Paid according to your PPO contract with BGFH Single source.
131		W45	Paid according to your PPO contract with NPPN/Universal/LA.
131		W46	Paid according to your PPO contract with NPPN/PPONext FKA Preferred Health Network.
131		W47	Paid according to your PPO contract with NPPN/Healthspan.
131		W48	Paid according to your PPO contract with NPPN/Dimension.
131		W49	Paid according to your PPO contract with NPPN/The Initial Group.
131		W4A	Paid according to your PPO contract with Healthsmart HPO/Integrated Health Plan/FPN.
131		W4B	Paid according to your PPO contract with Healthsmart HPO/Integrated Health Plan/NHP.
131		W4C	Paid according to your PPO contract with HPO/Managed Healthcare Northwest.
131		W4D	Paid according to your PPO contract with Healthsmart HPO/Rural Arizona Network.
131		W4E	Paid according to your PPO contract with NPPN/Genesis Physician Group.
131		W4F	Paid according to your PPO contract with Devon Network.

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 NPPN/Rural Arizona.
131		W4J	Paid according to your PPO contract with RAN Network.
131		W4K	Paid according to your PPO contract with HMN Network.
131		W4L	Paid according to your PPO contract with NPPN/Global Health Claim Service Network.
131		W4M	Paid according to your PPO contract with Galaxy/Managed Care Inc.
131		W4N	Paid according to your PPO contract with Plan Care America.
131		W4O	Paid according to your PPO contract with Coalition America.
131		W4P	Paid according to your PPO contract with Integrated Health Plan, Inc.
131		W4Q	Paid according to your PPO contract with IHP/Community Health Alliance.
131		W4R	Paid according to your PPO contract with IHP/FHN Health Network.
131		W4S	Paid according to your PPO contract with IHP/Flora Health Network.
131		W4T	Paid according to your PPO contract with IHP/Fortified Provider Network.
131		W4U	Paid according to your PPO contract with IHP/Galaxy Health Network.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W4V	Paid according to your PPO contract with IHP/Health First Network.
131		W4W	Paid according to your PPO contract with IHP/Health Care Network of America.
131		W4X	Paid according to your PPO contract with IHP/Medical Care Referral Group.
131		W4Y	Paid according to your PPO contract with IHP/Medical Resources.
131		W4Z	Paid according to your PPO contract with IHP/National Hospital Network.
131		W50	Paid according to your PPO contract with NPPN/Dimension/Tenet.
131		W51	Paid according to your PPO contract with NPPN/MH Net.
131		W52	Paid according to your PPO contract with NPPN/Virginia Health Network.
131		W53	Paid according to your PPO contract with NPPN/QualChoice of Arkansas.
131		W54	Paid according to your PPO contract with NPPN/First Choice Health/Sound Health.
131		W55	Paid according to your PPO contract with NPPN/MedicalControl.
131		W56	Paid according to your PPO contract with NPPN/800.557.1656.
131		W57	Paid according to your PPO contract with NPPN/CS-Direct.
131		W58	Paid according to your PPO contract with NPPN/HFN.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W59	Paid according to your PPO contract with NPPN/Heartland.
131		W5A	Paid according to your PPO contract with IHP/National Provider Network.
131		W5B	Paid according to your PPO contract with IHP/NPN Indiana Pro Health Network.
131		W5C	Paid according to your PPO contract with IHP/NPN Medical Network of Colorado Springs.
131		W5D	Paid according to your PPO contract with IHP/NPN Premier Care.
131		W5E	Paid according to your PPO contract with IHP/Preferred Care.
131		W5F	Paid according to your PPO contract with IHP/Preferred Care - Aiken SC.
131		W5G	Paid according to your PPO contract with IHP/Prime Health Services Inc.
131		W5H	Paid according to your PPO contract with IHP/ Provider Select Inc.
131		W5I	Paid according to your PPO contract with IHP/ TLC Advantage.
131		W5J	Paid according to your PPO contract with NPPN/Belin Health & Thedacare.
131		W5K	Paid according to your PPO contract with IHP/Medlink.
131		W5L	Paid according to your PPO contract with IHP/PSI/UHN.
131		W5M	Paid according to your PPO contract with IHP/FEDMED.
131		W5N	Paid according to your PPO contract with Provider Select (PSI).

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W5O	Paid according to your PPO contract with PMCS Networks.
131		W5P	Paid according to your PPO contract with America's PPO.
131		W5Q	Paid according to your PPO contract with Galaxy PPO.
131		W5R	Paid according to your PPO contract with Fortified Provider Network.
131		W5S	Paid according to your PPO contract with Independent Medical Systems.
131		W5T	Paid according to your PPO contract with IMS/CDA.
131		W5U	Paid according to your PPO contract with IMS/MCS.
131		W5V	Paid according to your PPO contract with PSI/Universal Health.
131		W5W	Paid according to your PPO contract with PSI/Preferred Care.
131		W5X	Paid according to your PPO contract with PSI/JerseyMed.
131		W5Y	Paid according to your PPO contract with PSI/MCRG.
131		W5Z	Paid according to your PPO contract with PPI/IHG/HPO.
131		W60	Paid according to your PPO contract with NPPN/CHN/NJ.
131		W61	Paid according to your PPO contract with Evolutions Healthcare Systems.
131		W62	Paid according to your PPO contract with FIPA/NAMM/PHYCOR Group.
131		W63	Paid according to your PPO contract with EHS/HPO Limited.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W64	Paid according to your PPO contract with EHS/Interplan.
131		W65	Paid according to your PPO contract with EHS/Intergroup.
131		W66	Paid according to your PPO contract negotiated agreement.
131		W67	Paid according to your PPO contract with EHS/Managed Care of America.
131		W68	Paid according to your PPO contract with EHS/Galaxy.
131		W69	Paid according to your PPO contract with EHS/Medical Resource.
131		W6A	Paid according to your PPO contract with NovaNet.
131		W6B	Paid according to your PPO Contract with Health Management Associates.
131		W6C	Paid according to your PPO Contract with Ashland Area Alliance PPO.
131		W6D	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6E	Paid according to your PPO Contract with Intergroup.
131		W6F	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6G	Paid according to your PPO Contract with IHG/Healthspan Preferred.
131		W6H	Paid according to your PPO Contract with IHG/HMA/Health Mgmt Ntwk Excl.
131		W6I	Paid according to your PPO Contract with IHG/HPO

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W6J	Paid according to your PPO Contract with HealthSmart HPO/PHP.
131		W6K	Paid according to your PPO Contract with IHG/NOMS.
131		W6L	Paid according to your PPO Contract with IHG/NorthCoast Health Solutions.
131		W6M	Paid according to your PPO Contract with HealthSmart/HPO.
131		W6N	Paid according to your PPO Contract with IHP/NPNCI Network
131		W6O	Paid according to your PPO Contract with Fed/MED/MPE/IHP.
131		W6P	Paid according to your PPO Contract with IHP/First Choice.
131		W6Q	Paid according to your PPO Contract with IHP/CoreChoice.
131		W6R	Paid according to your PPO Contract with NHBC
131		W6S	HealthSmart HPO/Health Coalition Partners.
131		W6X	Paid according to your PPO contract with PHCS Healthy Directions Network
131		W6Y	Paid according to your PPO contract with PHCS Network.
131		W6Z	Paid according to your PPO contract with Beech Street Network.
131		W70	Paid according to your PPO contract with EHS/PPONext.
131		W71	Paid according to your PPO contract with Post Acute Care.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W72	Paid according to your PPO contract with EHS/TRPN/HPO.
131		W73	Paid according to your PPO contract negotiated agreement.
131		W74	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica.
131		W75	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica (Shared Savings).
131		W76	Paid according to your PPO contract with NCN/Multiplan.
131		W77	Paid according to your PPO contract with NCN/American Care Source (ACS).
131		W78	Paid according to your PPO contract with Concentra/Multiplan.
131		W79	Paid according to your PPO contract with NPPN/Healthcare Direct.
131		W7A	Paid according to your PPO contract with ACPN.
131		W7B	Paid according to your PPO contract with USAMCO.
131		W7C	Paid according to your PPO contract with CCO.
131		W7D	Paid according to your PPO contract with HMNHI.
131		W80	Paid according to your PPO contract with NPPN/InterWest Health.
131		W81	Paid according to your PPO contract with NPPN/America's PPO.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W82	Paid according to your PPO Contract with NPPN/Comp Care of the Ozark s (CCO).
131		W83	Paid according to your PPO contract with NPPN/Accountable Health Plans.
131		W84	Paid according to your PPO contract with NPPN/PPOIN/ProHealth.
131		W85	Paid according to your PPO contract with NPPN/PPONext.
131		W86	Paid according to your PPO contract with NPPN/TRPN-FPN.
131		W87	Paid according to your PPO contract with NPPN/TRPN-QHP.
131		W88	Paid according to your PPO contract with PPONext.
131		W89	Paid according to your PPO contract with Mulitplan.
131		W90	Paid according to your PPO contract with NPPN/TRPN/MCS.
131		W91	Paid according to your PPO contract with NPPN/TRPN/Preferred Mental Health Management.
131		W94	Paid according to your PPO contract with NPPN/HPO/IHP/FPN.
131		W95	Paid according to your PPO contract with NPPN/HPO/IHP/NHP.
131		W96	Paid according to your PPO contract with NPPN/HPO/CHP.
131		W98	Paid according to your PPO contract with NPPN/HPO/HCP.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
131		W99	Paid according to your PPO contract with PHCS Healthy Directions Network.
131		WP5	Paid according to your PPO contract with America's PPO.
132	Prearranged demonstration project adjustment.	None	
	<i>Active: 2/28/97</i>		
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	None	
	<i>Start: 07/01/2014 Last Modified: 07/01/2017</i>	52M	Pending hospital audit.
134	Technical fees removed from charges.	None	
	<i>Start: 10/31/1998</i>		
135	Interim bills cannot be processed.	None	
135	<i>Start: 10/31/1998 Last Modified: 09/30/2007</i>	19M	Benefits cannot be considered until OB care has been completed. Please submit claim at that time.
135		527	Interim bills can not be processed. These services will be processed on final billing. Please submit claim when services completed.
135		70N	Interim Billing Declined. Resubmit claim with total billed charges with In-PT/Residential care is complete.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
136	Failure to follow prior payer's coverage rules. (Use Group Code OA)	None	
	<i>Start: 10/31/1998 Last Modified: 07/01/2013</i>		
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	None	
	<i>Start: 02/28/1999 Last Modified: 09/30/2007</i>		
138	<i>Appeal procedures not followed or time limits not met.</i>		
	<i>Start: 06/30/1999 Last Modified: 09/30/2007 Stop: 5/1/2018</i>		
139	Contracted funding agreement - Subscriber is employed by the provider of services. Effective 05/01/2018: Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	None	
	<i>Active: 6/30/99</i>		
140	Patient/Insured health identification number and name do not match.	None	
	<i>Start: 06/30/1999</i>		
141	<i>Claim spans eligible and ineligible periods of coverage.</i>	None	
	<i>Start: 06/30/1999 Last Modified: 09/30/2007 Stop: 07/01/2012</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
142	Monthly Medicaid patient liability amount. <i>Start: 06/30/2000 Last Modified: 09/30/2007</i>	None	
143	Portion of payment deferred. <i>Start: 02/28/2001</i>	None	
144	Incentive adjustment, e.g. preferred product/service. <i>Start: 06/30/2001</i>	None	
145	<i>Premium payment withholding.</i> <i>Start: 06/30/2002 Last Modified: 09/30/2007 Stop: 04/01/2008</i>	None	
146	Diagnosis was invalid for the date(s) of service reported.	None	
146	<i>Start: 06/30/2002 Last Modified: 09/30/2007</i>	118	No CPT/HCPCS code billed. According to the UB04 manual, this revenue code requires a CPT/HCPCS code. Please resubmit.
146		792	One or more diagnosis codes on this claim is not valid for the date(s) of service billed. Please resubmit with valid diagnosis code(s).
146		793	One or more diagnosis codes on this claim is not valid for the date(s) of service billed. Please resubmit with valid diagnosis code(s).
146		992	Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
147	Provider contracted/negotiated rate expired or not on file.	None	
	<i>Start: 06/30/2002</i>		
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	
	<i>Start: 06/30/2002 Last Modified: 09/20/2009</i>		
149	Lifetime benefit maximum has been reached for this service/benefit category.	None	
149	<i>Start: 10/31/2002</i>	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.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
149		L4A	Diabetes self management lifetime maximum has been met.
149		L4B	Bio feedback lifetime maximum has been met.
149		L6A	Donor cost lifetime maximum has been met.
149		L6B	Pharmacy lifetime maximum has been met.
149		L8A	Lifetime maximum for transplantation related expenses has been met.
150	Payer deems the information submitted does not support this level of service.	None	
150	<i>Start: 10/31/2002 Last Modified: 09/30/2007</i>	770	Claim review results. DRG has been changed based upon a review of the medical records.
150		775	Billed as Outpatient services; length of stay and/or review doesn't support Outpatient level. Rebill required.
150		776	Review results: Billed as Inpatient services; records review doesn't support Inpatient level. Rebill required. Explanation letter to follow.
150		783	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
150		784	Exceeds the maximum number of units for this service.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
150		785	Unable to price this service based on the information available. Billing requirements for APC/OPPS reimbursement have not been met.
150		846	Benefit limited. No history of nonsurgical therapy.
150		89A	Units billed exceed the maximum units allowed per day for this drug/medication. The units over the maximum have been denied.
150		89B	This patient has reached the maximum number of units of this drug/medication for this condition and the claim is denied.
150		89C	Units billed exceed the maximum units allowed per day for this diagnosis combination. The units over the maximum have been denied.
150		8A5	Benefit limited. No history of periodontal treatment.
150		999	Not Covered. No indication of failed reline or clinical stating reline would not be sufficient.
150		9F3	Based on consultant review standard of care not established. No benefit can be provided
150		9F5	Based on consultant review standard of care not established. No benefit can be provided
150		9H2	This is not covered. Chart notes do not provide justification for the treatment

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
151	Payment adjusted because the payer deems the information submitted does not support this many services/frequency of services.	None	
151	<i>Start: 10/31/2002 Last Modified: 01/27/2008</i>	02D	Unable to predetermine benefits for a buildup under an existing crown. Please submit clinical information when treatment is completed.
151		N11	This procedure is no longer considered clinically effective.
151		N29	Clinical daily maximum exceeded.
151		WGW	The billed units exceed the lifetime maximum for this procedure.
151		WGX	The total billed units for this procedure are medically unlikely.
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 10/31/2002 Last Modified: 07/01/2017</i>		
153	Payer deems the information submitted does not support this dosage.	None	
	<i>Start: 10/31/2002 Last Modified: 09/30/2007</i>		
154	Payer deems the information submitted does not support this day's supply.	None	
	<i>Start: 10/31/2002 Last Modified: 09/30/2007</i>		
155	Patient refused the service/procedure.	None	
	<i>Start: 06/30/2003 Last Modified: 09/30/2007</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
156	<i>Flexible spending account payments.</i>	None	
	<i>Start: 09/30/2003 Last Modified: 01/25/2009 Stop: 10/01/2009</i>		
157	Service/procedure was provided as a result of an act of war.	None	
	<i>Start: 09/30/2003 Last Modified: 09/30/2007</i>		
158	Service/procedure was provided outside of the United States.	None	
	<i>Start: 09/30/2003 Last Modified: 09/30/2007</i>		
159	Service/procedure was provided as a result of terrorism.	None	
	<i>Start: 09/30/2003 Last Modified: 09/30/2007</i>		
160	Injury/illness was the result of an activity that is a benefit exclusion.	None	
	<i>Start: 09/30/2003 Last Modified: 09/30/2007</i>		
161	Provider performance bonus.	None	
	<i>Start: 02/29/2004</i>		
162	<i>State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.</i>	None	
	<i>Start: 02/29/2004 Stop: 07/01/2014 Notes: Use code P1</i>		
163	Attachment/other documentation referenced on the claim was not received.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 06/30/2004 Last Modified: 06/02/2013</i>	73Q	Coordinaton of benefits updated; missing information. Please call customer service.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion. <i>Start: 06/30/2004 Last Modified: 06/02/2013</i>	None	
<i>165</i>	<i>Referral absent or exceeded.</i> <i>Start: 10/31/2004 Last Modified: 09/30/2007 Stop 5/1/2018</i>	None	
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	None	
166	<i>Start: 02/28/2005</i>	907	ODS is a third party administrator for North River Boats. Due to North River Boats' receivership, funds are not available to process claims.
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
167	<i>Start: 06/30/2005 Last Modified: 07/01/2017</i>	34M	Treatment for this diagnosis is not covered.
167		9F4	Our records indicate the pulp was previously removed from this tooth.
167		E34	Treatment for this diagnosis is not covered.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
168	<i>Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.</i>	None	
	<i>Start: 06/30/2005 Last Modified: 09/30/2007 Stop: 5/1/2018</i>		
169	Alternate benefit has been provided.	None	
169	<i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	70F	Units combined to apply appropriate member benefit.
169		70G	Mental Health claims are paid by GOBHI on behalf of EOCCO. Please rebill claim to GOBHI.
169		80R	Fees for 3 or 4 bitewing radiographic images have been given an alternate benefit of 2 bitewing images for patients through the age of 9.
169		817	If a tooth can be restored with a material such as amalgam or composite, payment will be based on the allowable for amalgam or composite.
169		818	Tooth colored (composite) fillings on back teeth are not a benefit. Allowance has been made for a silver (amalgam) filling.
169		823	Porcelain crowns, if posterior to the upper first molar and the lower second bicuspid are optional. Benefit is for a full gold crown.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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.
169		9F2	Complete and partial overdentures are considered specialized technique. An allowance has been made for a conventional denture.
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
170	<i>Start: 06/30/2005 Last Modified: 03/01/2017</i>	31M	This type of provider is not covered.
170		62M	The provider is not covered or working in a state approved program.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
170		7A5	The service is not covered. The attending dentist does not participate in ODS/Oregon Health Plan.
170		928	Benefits are provided for services, only if performed by an ODS/The Children's Program Participating Dentist.
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 06/30/2005 Last Modified: 07/01/2017</i>	None	
172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Start: 06/30/2005 Last Modified: 07/01/2017</i>	None	
173	Service was not prescribed by a physician. <i>Start: 06/30/2005 Last Modified: 07/01/2013</i>	None	
174	Service was not prescribed prior to delivery. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	
175	Prescription is incomplete. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
176	Prescription is not current. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	
177	Patient has not met the required eligibility requirements.	None	
177	<i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	S13	The member's coverage was not in effect on the date service was provided.
178	Patient has not met the required spend down requirements. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	
179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
179	<i>Start: 06/30/2005 Last Modified: 03/01/2017</i>	36E	No benefits can be paid for services related to this condition/procedure during the exclusionary period.
179		36M	No benefits can be paid for services related to this condition/procedure during the exclusionary period.
179		37E	No benefits can be paid for services related to this condition/procedure during the first six months of coverage.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
179		37M	No benefits can be paid for services related to this condition/procedure during the first six months of coverage.
179		908	The date of service is during the waiting period.
179		L5C	Service exclusionary period has not been met.
180	Patient has not met the required residency requirements. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	
181	Procedure code was invalid on the date of service.	None	
181	<i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	502	This procedure code is not valid for Medicare. Please resubmit with a valid code for reconsideration of benefits.
181		53B	This procedure code is not accepted for processing by Moda Health for this type of plan and/or line of business.
181		N13	This procedure is not a covered service under your plan.
182	Procedure modifier was invalid on the date of service. <i>Start: 06/30/2005 Last Modified: 09/30/2007</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 06/30/2005 Last Modified: 07/01/2017</i>		
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 06/30/2005 Last Modified: 03/01/2017</i>		
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 06/30/2005 Last Modified: 03/01/2017</i>		
186	Level of care change adjustment.	None	
	<i>Start: 06/30/2005 Last Modified: 09/30/2007</i>		
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	None	
	<i>Start: 06/30/2005 Last Modified: 01/25/2009</i>		
188	This product/procedure is only covered when used according to FDA recommendations.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 06/30/2005</i>		
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	None	
189	<i>Start: 06/30/2005</i>	12E	Claim review results. Not otherwise classified or "unlisted" CPT/HPCS code billed. Specific code available for this procedure/service.
189		710	Not Otherwise classified or "unlisted" code cannot be used. There is a specific procedure code for this procedure/service.
189		790	Not Otherwise classified' or 'unlisted' code cannot be used. There is a specific procedure code for this procedure/services.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	None	
	<i>Start: 10/31/2005</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
191	<i>Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)</i>	None	
	<i>Start: 10/31/2005 Last Modified: 10/17/2010 Stop: 07/01/2014 Notes: Use code P2</i>		
192	Non standard adjustment code from paper remittance. Usage: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	None	
	<i>Start: 10/31/2005 Last Modified: 07/01/2017</i>		
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	None	
	<i>Active: 2/28/06 Last Modified: 01/27/2008</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	None	
	<i>Active: 02/28/06 Modified: 09/30/07</i>		
195	Refund issued to an erroneous priority payer for this claim/service.	None	
	<i>Active: 02/28/06 Modified: 09/30/07</i>		
196	<i>Claim/service denied based on prior payer's coverage determination.</i>	None	
	<i>Start: 06/30/2006 Stop: 02/01/2007 Use code 136</i>		
197	Precertification/authorization/notification/pre-treatment absent.	None	
197	<i>Start: 10/31/2006 Last Modified: 5/1/2018, 09/30/2007</i>	016	Reduced Allowable Amount per Unit
197		018	Reduced Allowable Units
197		01M	Benefit reduced because of non-compliance with cost containment provision of contract
197		040	Valid Referral and/or Pre-authorization not obtained.
197		04M	This service requires a referral.
197		134	No record of pre-authorization from Moda Behavioral on file for this service
197		135	No record of pre-authorization on file. No benefits can be allowed.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
197		20M	This service is not covered. No prior authorization on record.
197		21M	This service requires a referral or an authorization.
197		532	No prior authorization obtained for this service/item as required by Moda Health Advantage. Do not bill member.
197		708	This service is not covered. No prior authorization on record.
197		81D	Benefits are payable only when treatment has been pre-determined.
197		81H	Services were disallowed by Utilization Management due to no authorization on file at the time services were rendered.
197		81T	Units exceed a utilization management authorization.
197		893	Predetermination of benefits is required for services performed by a non participating provider.
197		M21	This service requires an authorization.
197		UD	Amount Disallowed by Utilization Management.
197		UED	Utilization Edit Denial.
197		UM0	Services were Disallowed by Utilization Management due to no authorization on file at the time services were rendered.
197		UM1	Units exceed a utilization management authorization.

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.
197		UM3	Claim matched to a pended UM therefore zero units are allowed.
198	Precertification/authorization exceeded. 05/01/2018: Precertification/notification/authorization/pre-treatment exceeded.	None	
198	<i>Start: 10/31/2006 Last Modified: 09/30/2007</i>		
199	Revenue code and Procedure code do not match.	None	
199	<i>Start: 10/31/2006</i>	80G	Revenue code and Procedure code do not match. Please rebill with an appropriate revenue code for the services billed.
199		81C	Revenue code and Procedure code do not match. Please rebill with an appropriate revenue code for the services billed.
200	Expenses incurred during lapse in coverage.	None	
	<i>Start: 10/31/2006</i>		
201	Patient is responsible for amount of this claim/service through "set aside arrangement" or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.	None	
	<i>Start: 10/31/2006 Last Modified: 09/28/2014</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
202	Non-covered personal comfort or convenience services.	None	
202	<i>Start: 02/28/2007 Last Modified: 09/30/2007</i>	504	Personal comfort items are not covered.
203	Discontinued or reduced service.	None	
	<i>Start: 02/28/2007 Last Modified: 09/30/2007</i>		
204	The service/equipment/drug is not covered under the patient's current benefit plan.	None	
204	<i>Start: 02/28/2007</i>	02M	Classes and other educational/instructional services or materials are not covered.
204		09N	This service/expense is not covered.
204		11M	Non-covered drug/supply.
204		125	State and/or local taxes are not covered.
204		12M	There is no benefit for mailing or handling fees.
204		25M	No coverage for telephone consultation.
204		26M	Charges for missed appointments are not covered.
204		27M	Routine immunization not covered.
204		29M	Medications not requiring a doctor's prescription are excluded by the plan.
204		38M	Charges for reports and/or finance charges are not covered.
204		516	Non-durable medical equipment is not covered.

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		540	This provider is not approved to perform MTM services under this plan. ODS Advantage MTM services are performed by in-house staff only.
204		542	Medicare covers another similar item, but this upgrade model or version is not covered. Claim indicates you were notified and agreed to pay.
204		543	Medicare/ODS Advantage does not cover this method of monitoring your diabetes. Benefits available for blood glucose testing supplies.
204		544	Medicare/ODS Advantage does not cover services, items, or medications to prevent pregnancy.
204		545	Medicare/ODS Advantage does not cover food allergy testing and treatment.
204		546	Medicare/ODS Advantage does not cover transportation in vehicle other than ambulance.
204		547	Medicare/ODS Advantage covers transportation only to the closest facility that can provide the necessary care.
204		548	This item is for use as a compression/surgical dressing and is not covered by Medicare/ODS Advantage.
204		549	Medicare/ODS Advantage covers CPM devices only for the knee and not for this joint or body part.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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 measurement. Another covered test is available and should have been used.
204		565	This vision service is not covered for a routine vision diagnosis by Original Medicare or your ODS Advantage plan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		566	The covered portion of this item/service is billed under another code. This portion/upgrade feature is not covered under your plan.
204		567	This is a routine service that does not fall within the list of routine services covered by Original Medicare or your ODS Advantage plan.
204		568	Medicare considers this a personal comfort item and not a covered benefit under Medicare/ODS Advantage. Claim indicates you agreed to pay.
204		569	This item has been forwarded for processing under Part D.
204		570	This medication or item is covered under Medicare Part D. Your ODS Advantage plan does not include Part D coverage.
204		571	The information provided does not support that you meet the criteria to be considered homebound.
204		572	Noncovered. Evidence shows this service does not improve the outcome for the condition it is intended to diagnose or treat.
204		573	The information provided does not support that conventional therapy has been used or has been unsuccessful.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		574	Medicare/ODS Advantage does not cover biofeedback for the diagnosis listed on this claim. Claim indicates you agreed to pay.
204		575	Medicare/ODS Advantage does not cover this service for the diagnosis listed on this claim. Claim indicates you agreed to pay.
204		576	Medicare/ODS Advantage does not cover this surgical procedure for back problems. Other procedures are covered when requirements are met.
204		59M	Your medical plan excludes this type of dental service/supply. If you also have ODS Dental, your claim will be referred to our Dental dept.
204		61M	The medical plan excludes this type of dental service/supply.
204		762	Claim review results. Services determined to be cosmetic upon audit review. Not a covered benefit.
204		763	Claim review results. Services determined to be investigational upon audit review. Not a covered benefit.
204		786	This service/expense is not covered
204		80D	Accident related procedures are not covered under this dental plan.
204		815	No payment is provided for the following fees: periodontal charting, office calls, consultations, or broken appointments.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		81A	Covered for a pregnant member or member 16 to 20 years old.
204		81E	Braces are only covered to treat cleft palate or Cleft Lip
204		81N	Covered for a pregnant member or member 16 to 20 years old.
204		81O	This service is not covered. Covered only for members under 21.
204		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		89E	This type of test is not a covered benefit.
204		978	Not covered because you are over age 21 and are not pregnant.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		9A0	This service is not covered.
204		9A9	This service is not covered.
204		9AR	Covered only for members under 21.
204		9B3	Service is covered only for members age 16 through 20.
204		9B4	Benefit is only provided when done on front teeth.
204		9B5	This service is not covered. The fee for this service is considered part of the exam, another service, or follow up care.
204		9C2	Benefit is only provided when done on front teeth.
204		9C3	This service is not covered. Only covered for members 16 to 20 years old.
204		9C4	This service is not covered. A separate payment is not given for temporary treatment or to prepare the tooth.
204		9C5	This type of partial is not a covered benefit.
204		9C7	Temporary dentures are not a covered benefit.
204		9D3	Implant services are not covered.
204		9D4	Bridge services are not covered.
204		9D5	Covered for a pregnant member or member under 21 years old.
204		9D6	Orthodontia only covered to correct cleft palate.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
204		9D7	Benefit is only provided when done on back teeth.
204		9D8	This exam is not covered with routine dental visits.
204		9E0	The service is not covered for second molars and wisdom teeth. You are not pregnant or under the age of 21.
204		9F0	The service is not covered for second molars and wisdom teeth. You are not pregnant or under the age of 21.
204		9G3	Crown is not covered on this tooth
204		9G5	Temporary treatment is not covered
204		9J0	This type of Partial is not a covered benefit.
204		E49	Payment is not provided for procedures or appliances for splinting of teeth.
205	Pharmacy discount card processing fee. <i>Start: 07/09/2007</i>	None	
206	National Provider Identifier - missing. <i>Start: 07/09/2007 Last Modified: 09/30/2007</i>	None	
207	National Provider Identifier - Invalid format. <i>Start: 07/09/2007 Last Modified: 06/01/2008</i>	None	
208	National Provider Identifier - Not matched. <i>Start: 07/09/2007 Last Modified: 09/30/2007</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	
	<i>Start: 07/09/2007 Last Modified: 07/01/2013</i>		
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	None	
	<i>Start: 07/09/2007</i>		
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	None	
	<i>Start: 07/09/2007</i>		
212	Administrative surcharges are not covered.	None	
	<i>Start: 11/05/2007</i>		
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	None	
	<i>Start: 01/27/2008</i>		
214	<i>Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)</i>	None	
	<i>Start: 01/27/2008 Last Modified: 10/17/2010 Stop: 07/01/2014</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
215	Based on subrogation of a third party settlement	None	
215	<i>Start: 01/27/2008</i>	0M3	Payment reduction for Subro - Auto.
215		0M4	Payment reduction for Subro - Work Comp.
215		0M5	Payment reduction for Subro - Other.
216	Based on the findings of a review organization.	None	
	<i>Start: 01/27/2008</i>		
217	<i>Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)</i>	None	
	<i>Start: 01/27/2008 Last Modified: 09/30/2012 Stop: 07/01/2014</i>		
218	<i>Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only</i>	None	
	<i>Start: 01/27/2008 Last Modified: 09/30/2012 Stop: 07/01/2014</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
219	Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	None	
	<i>Start: 01/27/2008 Last Modified: 07/01/2017</i>		
220	<i>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)</i>	None	
	<i>Active: 1/27/08 Modified: 9/30/2012 Deactivated: 7/1/2014</i>		
221	<i>Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Active: 1/27/08 Modified: 9/30/2012 Deactivated: 7/1/2014</i>		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
	<i>Start: 06/01/2008 Last Modified: 07/01/2017</i>		
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.		
	<i>Start: 06/01/2008</i>		
224	Patient identification compromised by identity theft. Identify verification required for processing this and future claims.		
	<i>Start: 06/01/2008</i>		
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)		
	<i>Start: 06/01/2008</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)		
226	<i>Start: 09/21/2008 Last Modified: 07/01/2013</i>	42M	Partial payment only; remainder of charges being held pending receipt of additional information requested from the provider.
226		48C	Information requested from the provider has not been received. Benefit has been made for the assessment fee.
226		48P	Information requested from the provider(s) regarding pre-existing conditions has not been received.
226		48R	Information requested from the provider about medical records necessary to process this claim has not been received.
226		712	Records for review & note explaining correction must be attached to corrected claims. (FYI - No corrected claims after an audit review.)
226		758	Claim review result. No response to records request. Audit will be reopened if records received within 30 days.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		769	Review results. Incomplete response to records request. Audit will be re-opened if missing records/items received within 30 days.
226		80A	Current panoramic and cephalometric radiographs, intraoral and extraoral photographs, and medical necessity not received from provider.
226		89N	Chart notes showing preparation date and seat date have not been received from the dentist.
226		932	This service is not covered. Chart notes and diagnosis of the treatment has not been received from the dentist to confirm need.
226		933	This service is not covered. Chart notes and PA x-rays have not been received from the dentist to confirm treatment is needed.
226		934	This service is not covered. Report and location of the tissue being removed has not been received from the dentist.
226		935	This service is not covered. Pocket charting and date of last periodontal service (gum treatment) has not been received from the dentist.
226		936	Periodontal charting, periapical x-ray, and diagnosis was not received from the provider to confirm necessity.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		937	Periodontal charting, periapical x-ray of the abutment teeth and the opposing arch was not received from the provider to confirm necessity
226		938	Material used was not received from the provider to confirm necessity.
226		939	Pre and post service x-rays were not received from dentist to confirm need.
226		940	Current periapical x-ray not received from the provider to confirm necessity.
226		941	This service is not covered. Chart notes on teeth being replaced and clasped and PA x-ray of abutment teeth not received from the dentist.
226		942	This service is not covered. Panoramic and PA x-rays not received from the dentist to confirm need.
226		943	Chart notes showing if this is the first step of a root canal has not been received from the dentist.
226		944	Chart notes showing if this is the first step of a root canal has not been received from the dentist.
226		945	This service is not covered. Chart notes with missing teeth, teeth being clasped, PA x-ray, and pocket charting not received from dentist.
226		946	This service is not covered. Chart notes showing the final repair and PA x-rays have not been received from the dentist.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
226		948	Narrative, current periapical x-ray and photograph was not received from the provider to confirm necessity.
226		204	Additional information requested from provider was not received. Services denied to provider responsibility. Do not bill patient.
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	None	
227	<i>Start: 09/21/2008 Last Modified: 09/20/2009</i>	48A	Information requested from the member about accident details for the conditions on this claim has not been received.
227		48B	Information requested from the member about other insurance coverage has not been received.
227		48D	Information requested from the member on the accident claim letter has been received, but was incomplete.
227		48I	Information requested from the member on the student verification form has been received but was incomplete.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
227		48S	Information requested from the member on the student verification form has not been received.
227		48T	Information requested from the member about third party liability for the conditions on this claim has not been received.
227		48X	Information requested from the member regarding pre-existing conditions has not been received.
227		510	Requested information not received-Patient.
227		Z03	Additional information requested from member was not received. Services denied to member responsibility.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	None	
	<i>Start: 09/21/2008</i>		
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Usage: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	None	
	<i>Start: 01/25/2009 Last Modified: 07/01/2017</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
230	<i>No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.</i>	None	
	<i>Start: 01/25/2009 Deactivated: 7/1/2014</i>		
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 07/01/2009 Last Modified: 07/01/2017</i>		
232	Institutional Transfer Amount. Usage - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	None	
	<i>Start: 11/01/2009 Last Modified: 07/01/2017</i>		
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	None	
	<i>Start: 01/24/2010</i>		
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	None	
	<i>Start: 01/24/2010</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
235	Sales Tax	None	
	<i>Start: 06/06/2010</i>		
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	None	
	<i>Start: 01/30/2011 Last Modified: 07/01/2013</i>		
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	None	
	<i>Start: 06/05/2011</i>		
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	None	
	<i>Start: 03/01/2012 Last Modified: 07/01/2013</i>		
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	None	
	<i>Start: 03/01/2012 Last Modified: 01/29/2012</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 06/03/2012 Last Modified: 07/01/2017</i>		
241	Low Income Subsidy (LIS) Co-payment Amount	None	
	<i>Start: 06/03/2012</i>		
242	Services not provided by network/primary care providers.	None	
	<i>Start: 06/03/2012 Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38</i>	129	Use of an in-network provider is required for a higher level of benefits.
		132	Services performed by out-of-network providers are not covered. Refer to the physicians and providers section of the member handbook.
243	Services not authorized by network/primary care providers.	None	
	<i>Start: 06/03/2012 Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38</i>		
244	<i>Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.</i>	None	
	<i>Start: 9/30/2012 Deactivated: 7/1/2014</i>		
245	Provider performance program withhold.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 09/30/2012</i>		
246	This non-payable code is for required reporting only.	None	
	<i>Start: 09/30/2012</i>	505	This service is only payable by original Medicare and/or Medicaid. No allowance; for reporting purposes only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	None	
	<i>Start: 09/30/2012</i> <i>Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).</i>		
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	None	
	<i>Start: 09/30/2012</i> <i>Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).</i>		
249	This claim has been identified as a readmission. (Use only with Group Code CO)	None	
	<i>Start: 09/30/2012</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT	None	
	<i>Start: 09/30/2012 Last Modified: 06/01/2014</i>	730	Coordination of benefits updated; unable to verify other carrier information or unknown carrier.
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	None	
	<i>Start: 09/30/2012 Last Modified: 06/01/2014</i>	73N	Primary payment estimated; Primary EOB does not match DOS/Service billed.
		73R	Coordination of benefits updated; custody/mandate information needed
		73S	Coordination of benefits updated; due to dependent age/expiration of mandate.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	None	
252	<i>Start: 09/30/2012 Last Modified: 06/01/2014</i>	33L	Please submit a complete itemization of services, including medical diagnosis, description, and charge for each service.
252		33M	Please submit a complete itemization of services, including medical diagnosis, description and charge for each service.
252		9F6	Covered only when submitted with ADA Caries Risk Assessment form.
253	Sequestration - reduction in federal payment <i>Start: 06/02/2013 Last Modified: 11/01/2013</i>	None	
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	None	
254	<i>Start: 06/02/2013</i>	06D	Dental plans are secondary on treatment for accidental injury to the natural teeth. A medical plan's Explanation Of Benefits is required.
254		70B	Implants may be covered under Aetna. For details, call 1-855-784-8646 . Once Aetna has reviewed please resubmit the claim with Aetna's EOB.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
254		81F	This service is not covered by dental. Please submit to your medical carrier.
254		81Q	This service is not covered by dental please submit to your medical carrier. . Once Aetna has reviewed please resubmit the claim with Aetna's EOB.
255	<i>The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		
256	Service not payable per managed care contract.	None	
	<i>Start: 06/02/2013</i>		
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	None	
	<i>Start: 11/01/2013 Last Modified: 06/01/2014 Notes: To be used after the first month of the grace period.</i>		
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 11/01/2013</i>		
259	Additional payment for Dental/Vision service utilization	None	
	<i>Start: 01/26/2014</i>		
260	Processed under Medicaid ACA Enhanced Fee Schedule	None	
	<i>Start: 01/26/2014</i>		
261	The procedure or service is inconsistent with the patient's history.	None	
	<i>Start: 06/01/2014</i>		
262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only	None	
	<i>Start: 11/01/2014 Last Modified: 07/01/2017</i>		
263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only	None	
	<i>Start: 11/01/2014 Last Modified: 07/01/2017</i>		
264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only	None	
	<i>Start: 11/01/2014 Last Modified: 07/01/2017</i>		
265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	None	
	<i>Start: 11/01/2014 Last Modified: 07/01/2017</i>		
266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 11/01/2014 Last Modified: 07/01/2017</i>		
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an Alert.	None	
	<i>Start: 11/01/2014 Last Modified: 04/01/2015</i>		
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	None	
	<i>Start: 11/01/2014</i>		
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 03/01/2015 Last Modified: 07/01/2017</i>		
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration		
	<i>Start: 07/01/2015</i>		
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)		
	<i>Start: 11/01/2015</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
272	Coverage/program guidelines were not met. <i>Start: 11/01/2015</i>	522	Not covered because coverage requirements and/or plan/program guidelines were not met.
273	Coverage/program guidelines were exceeded. <i>Start: 11/01/2015</i>	None	
274	Fee/Service not payable per patient Care Coordination arrangement. <i>Start: 11/01/2015</i>	None	
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR) <i>Start: 11/01/2015</i>	None	
276	Services denied by the prior payer(s) are not covered by this payer <i>Start: 11/01/2015</i>	None	
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 11/01/2015</i>		
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 07/01/2016 Last Modified: 07/01/2017</i>		
279	Services not provided by Preferred network providers	None	
	<i>Start: 11/1/2016</i>		
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	None	
	<i>Start: 3/1/2017</i>		
281	Deductible waived per contractual agreement. Use only with Group Code CO.	None	
	<i>Start: 7/1/2017</i>		
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Start: 7/1/2017</i>		
283	Attending provider is not eligible to provide direction of care.	None	
	<i>Start: 11/1/2017</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services. <i>Start: 11/1/2017</i>	None	
285	Appeal procedures not followed <i>Start: 11/1/2017</i>	None	
286	Appeal time limits not met <i>Start: 11/1/2017</i>	None	
		H38	Appeal procedures not followed or time limits not met.
		H39	Appeal procedures not followed or time limits not met.
287	Referral exceeded. <i>Start: 11/1/2017</i>	None	
288	Referral absent	None	
288	<i>Start: 11/1/2017</i>	128	A referral by the Primary Care Physician (PCP) is required for a higher level of benefits.
288		130	A referral by the Primary Care Physician (PCP) is necessary to avoid denial of benefits.
288		740	This service is not covered. There is no referral from your primary care dentist.
288		9D9	This service is not covered. There is no referral from your primary care dentist.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
289	Services considered under the dental and medical plans, benefits not available. Notes: Also see CARCs 254, 270 and 280.	None	
	<i>Start: 11/1/2017</i>		
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration. Notes: Also see CARCs 254, 270 and 280.	None	
	<i>Start: 11/1/2017</i>		
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration	None	
	<i>Start: 11/1/2017</i>		
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration	None	
	<i>Start: 11/1/2017</i>		
293	Payment made to employer	None	
	<i>Start: 5/1/2018</i>		
294	Payment made to attorney.	None	
	<i>Start: 11/1/2017</i>		
295	Pharmacy Direct/Indirect Remuneration (DIR)	None	
	<i>Start: 3/1/2018</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
279	Services not provided by Preferred network providers <i>Start: 11/01/2016</i>		
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration. <i>Start: 03/01/2017</i>		
A0	Patient refund amount. <i>Active: 1/1/95</i>	None 587	Member Request for reimbursement.
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) <i>Active: 1/1/95 Last Modified: 10/31/06 Eff 6/1/07 At least one Remark Code must be provided.09/20/2009</i>	None 764	Claim review results. These items are supplies which cannot be billed as implants.
A2	Contractual adjustment. <i>Active: 1/1/95 Last Modified: 2/28/07 Deactivated on 1/1/08</i>	None	
A4	Medicare Claim PPS Capital Day Outlier Amount. <i>Active: 1/1/95 Last Modified: 09/30/2007 Stop: 04/01/2008</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
A5	Medicare Claim PPS Capital Cost Outlier Amount. <i>Active: 1/1/95</i>	None	
A6	Prior hospitalization or 30 day transfer requirement not met. <i>Active: 1/1/95</i>	None	
A7	<i>Presumptive Payment Adjustment.</i> <i>Active: 1/1/95 Deactivated: 7/1/2015</i>	<i>None</i>	
A8	Ungroupable DRG. <i>Active: 1/1/95 Last Modified: 09/30/2007</i>	None	
B1	Non-covered visits. <i>Active: 1/1/95</i>	None	
B4	Late filing penalty. <i>Active: 1/1/95</i>	None	
B5	<i>Coverage/program guidelines were not met or were exceeded.</i>	<i>None</i>	
B5	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	522	<i>Not covered because coverage requirements and/or plan/program guidelines were not met.</i>

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
B7	<i>Active: 1/1/95 Last Modified: 07/1/217, 9/20/09,10/31/98</i>	70C	DMAP registration required for payment. Go to https://www.modahealth.com/dental/forms.shtml for a DMAP enrollment application.
B7		7A4	DMAP registration required for payment. Go to https://www.modahealth.com/dental/forms.shtml for a DMAP enrollment application.
B7		84M	DMAP registration required for payment. Go to http://eocco.com/providers/become-provider.shtml for an application.
B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	None	
	<i>Active: 1/1/95 Modified: 07/1/17, 9/20/09, 9/30/07</i>		
B9	Patient is enrolled in a Hospice.	None	
B9	<i>Active: 1/1/95 Modified: 9/30/07</i>	9B9	Services not covered because the patient is enrolled in Hospice.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
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	
	<i>Active: 1/1/95</i>		
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	None	
	<i>Active: 1/1/95</i>		
B12	Services not documented in patient's medical records.	None	
B12	<i>Active: 1/1/95 Last modified: 3/1/2018</i>	756	Claim review results. Service not documented. This is the incorrect code to use for billing the service documented in the medical record.
B12		757	Claim review results. Key required elements for this service/item not documented in records received. No separate allowance can be made.
B12		759	Review results. Calculation error. The dose or number of items documented in the record does not match the dose or number of units billed.
B12		760	Claim review results. Item denied or adjusted. Letter to follow containing further explanation (if out of network, member is copied).

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B12		767	Claim review results. Item denied or adjusted. Letter to follow containing further explanation (if out of network, member is copied).
B12		768	Review results. Service not documented. There is no documentation in the submitted medical records to support billing this item or service.
B12		772	Claim review results. Service/item not documented. There is no documentation in the medical record to support billing this item or service.
B12		777	Review. Incomplete records request response. Documentation for this date of service and/or line item not included in submitted records.
B12		787	Please provide proof of loss in the form of a cancelled check or a copy of a bank or credit card statement documenting payment.
B12		9E1	Services either not documented or incomplete and insufficient documentation. Requirements not met to support billing this code.
B12		9E2	Time not (or not correctly) documented. Code billed based on amount of time performed. Documentation incomplete, services not supported.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B12		Z05	Documentation does not support services billed. Denied. Do not bill patient.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. <i>Active: 1/1/95</i>	None	
B14	Only one visit or consultation per physician per day is covered. <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	None	
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <i>Active: 1/1/95 Modified: 7/1/17, 9/20/09, 9/30/07, 10/31/06</i>	None	
B16	New Patient' qualifications were not met. <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	WGK	Our records show patient has been treated by this provider/clinic within the past 3 years. Criteria for new patient code has not been met.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
B18	<i>This procedure code/modifier was invalid on the date of service or claim submission.</i>	None	
	<i>Active: 1/1/95 Modified: 9/30/07 Stop: 03/01/2009</i>		
B20	Procedure/service was partially or fully furnished by another provider.	None	
	<i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	717	Our records indicate procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.	None	
	<i>Active: 1/1/95 Last Modified: 2/28/01</i>		
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	None	
	<i>Active: 1/1/95 Modified: 2/28/01</i>		
D16	<i>Claim lacks prior payment information.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		
D17	<i>Claim/Service has invalid non-covered days.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		
D18	<i>Claim/Service has missing diagnosis information.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
D19	<i>Claim/Service lacks Physician/Operative or other supporting documentation.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		
D20	<i>Claim/Service missing service/product information.</i>	None	
	<i>Active: 1/1/95 Deactivated: 6/30/07</i>		
D22	<i>Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) -- Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code</i>	None	
	<i>Active: 1/27/08 To Be Deactivated: 1/1/09</i>		
D23	<i>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.)</i>	None	
	<i>Start: 11/01/2009 Stop: 01/01/2012</i>		
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P2	<p>Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.</p>	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		
P3	<p>Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)</p>	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P6	Based on entitlement to benefits. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P8	Claim is under investigation. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	None	
	<i>Start: 11/1/2013</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P12	<p>Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.</p>	None	
	<p><i>Start: 11/1/2013 Last modified: 7/1/2017</i></p>		
P13	<p>Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.</p>	None	
	<p><i>Start: 11/1/2013 Last modified: 7/1/2017</i></p>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013 Last modified: 7/1/2017</i>		
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	None	
	<i>Start: 11/1/2013</i>		
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	None	
	<i>Start: 11/1/2013</i>		
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	None	
	<i>Start: 11/1/2013</i>		
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only	None	
	<i>Start: 11/1/2013 Last modified: 3/1/18, 7/1/17</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
P22	<p>Payment adjusted based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.</p>	None	
	<p><i>Start: 11/1/2013 Last modified: 3/1/18, 7/1/17</i></p>		

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

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
W2	<p><i>Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.</i></p>	None	
	Start: 10/17/2010 Deactivated: 7/1/2014		
W3	<p><i>The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.</i></p>	None	
	Start: 9/30/2012 Deactivated: 7/1/2014		
W4	<p><i>Workers' Compensation Medical Treatment Guideline Adjustment.</i></p>	None	
	Start: 9/30/2012 Deactivated: 7/1/2014		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
W5	<i>Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		
W6	<i>Referral not authorized by attending physician per regulatory requirement.</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		
W7	<i>Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		
W8	<i>Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		
W9	<i>Service not paid under jurisdiction allowed outpatient facility fee schedule.</i>	None	
	<i>Start: 6/2/2013 Deactivated: 7/1/2014</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
Y1	<p><i>Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.</i></p> <p><i>Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.</i></p>	None	
	<p><i>Start: 9/30/2012 Modified: 6/2/2013</i></p> <p><i>Deactivated: 7/1/2014</i></p>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
Y2	<p><i>Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.</i></p>	None	
	<p><i>Start: 9/30/2012 Modified: 6/2/2013 Deactivated: 7/1/2014</i></p>		
Y3	<p><i>Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.</i></p>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	Facets EXCD	Explanation Code Description
	<i>Start: 9/30/2012 Modified: 6/2/2013 Deactivated: 7/1/2014</i>		