

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
1	Deductible Amount.	None	
	Active: 1/1/95	500	Medicare deductible.
2	Co-insurance Amount.	None	
	Active: 1/1/95		
3	Co-payment Amount.	None	
	Active: 1/1/95	D99	Co-pay applied.
		801	Patient is responsible for \$10.00 office visit.
		146	The patient is responsible for this copay for specific services at Monacare Health Clinic.
		147	Patient is not responsible for these Monacare Health Clinic charges. Disregard patient amounts in this line item--for reporting only.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	None	
	Active: 1/1/95		
5	The procedure code/bill type is inconsistent with the place of service.	None	
	Active: 1/1/95	U14	The place of service is inconsistent with the procedure that was performed.
6	The procedure/revenue code is inconsistent with the patient's age.	None	
	Active: 1/1/95	I9	The service is not allowed due to the patient's age.
		PC	This service is applicable to children only.
		RC	This service is applicable to children only.
		R9	This service is not allowed due to the patient's age.
		WC	This service is applicable to children only.
		W9	The service is not allowed due to the patient's age.
	Y9	This service is not allowed due to the patient's age.	
7	The procedure/revenue code is inconsistent with the patient's gender.	None	
	Active: 1/1/95	U05	The services rendered for this procedure are not medically indicated as appropriate for this patient.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	None	
	Active: 1/1/95		
9	The diagnosis is inconsistent with the patient's age.	None	
	Active: 1/1/95		
10	The diagnosis is inconsistent with the patient's gender.	None	
	Active: 1/1/95	U06	The services rendered for this diagnosis are not medically indicated as appropriate for this patient.
11	The diagnosis is inconsistent with the procedure.	None	
	Active: 1/1/95	46	The diagnosis is inconsistent with the service billed. Please resubmit with a corrected diagnosis or procedure code.
		68	This type of treatment is not covered for this diagnosis.
12	The diagnosis is inconsistent with the provider type.	None	
	Active: 1/1/95		
13	The date of death precedes the date of service.	None	
	Active: 1/1/95		
14	The date of birth follows the date of service.	None	

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	<i>Active: 1/1/95</i>	>1	The date of service is before dependent's date of birth.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. <i>Active: 1/1/95</i> <i>Modified: 2/28/01, 09/30/07</i>	None	
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using Remittance Advice Remark codes whenever appropriate.	None	
	<i>Active: 1/1/95 Modified: 6/30/06 Effective 4/1/07 a Remark Code must be provided.</i>	42	Partial payment only; remainder of charges are being held pending receipt of additional information requested from the provider.
		58	Please submit medical records for utilization review of pending days.
		60M	Provider is requested to submit claim for pricing to: Cofinity, 6501 South Fiddler's Green Road Ste. 300, Greenwood Village, CO 80111.
		64	Received balance due statement only. Please submit itemized charges from this provider.
		81	Partial payment only. The remainder of the claim has been returned for additional information.
		107	The provider is requested to submit a description of this service/supply.
		113	For further consideration, the provider needs to submit chart notes for this date of service.
		675	Clinical information requested to determine benefits. Please submit sufficient clinical evidence of necessity.
		916	Claim/service lacks information which is needed for adjudication.
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code)	None	
	<i>Active: 1/1/95 Modified: 6/30/06, 9/30/07 Effective 4/1/07 a Remark Code must be provided.</i>	48A	Information requested from the member about accident details for the conditions on this claim has not been received.
		48B	Information requested from the member about other insurance coverage has not been received.
		48C	Information requested from the provider has not been received. Benefit has been made for the assessment fee.
		48D	Information requested from the member on the accident claim letter has been received, but was incomplete.
		48I	Information requested from the member on the student verification form has been received but was incomplete.
		48O	Information requested from other provider(s) has not been received.
		48P	Information requested from the provider (s) regarding pre-existing conditions has not been received.
		48R	Information requested from the provider about medical records necessary to process this claim has not be received.
		48S	Information requested from the member about third party liability for the conditions on this claim has not been received.
		48T	Information requested from the member about third party liability for the conditions on this claim has not been received.

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		48X	Information requested from the member regarding pre-existing conditions has not been received.
		917	Payment adjusted because requested information was not provided or was insufficient/incomplete
18	Duplicate claim/service.	None	
	<i>Active: 1/1/95</i>	Q1	This service is a duplicate of a previously processed service or is currently in process. Please check your records.
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	None	
	<i>Active: 1/1/95 Modified: 9/30/07</i>	67	Work related claims are not covered.
20	This injury/illness is covered by the liability carrier.	None	
	<i>Active: 1/1/95 Modified: 9/30/07</i>	07	Please submit this claim to your auto insurance carrier for a determination of their benefits.
		153	No payment is provided because the charge(s) are expected to be paid by the third party liability carrier.
		154	No payment is provided because the charge(s) are expected to be paid out of the third party settlement.
		155	No payment is provided because the charge(s) are expected to be paid by the motor vehicle carrier.
21	This injury/illness is the liability of the no-fault carrier.	None	
	<i>Active: 1/1/95 Modified: 09/30/07</i>		
22	This care may be covered by another payer per coordination of benefits.	None	
	<i>Active: 1/1/95. Modified: 2/28/01, 09/30/07</i>	>M	Medicare coverage.
		D76	If primary insurance did not pay the amount as shown, please submit a copy of their explanation of benefits for review and/or an adjustment.
		57	Please send Medicare's explanation of benefits for this claim.
		74	Please submit a copy of the primary carrier's explanation of benefits. Your claim will be reviewed/adjusted when we received this information.
		06D	Dental plans are secondary on treatment for accidental injury to the natural teeth. A medical plan's Explanation of Benefits is required.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	None	
	<i>Active: 1/1/95. Modified: 6/30/05, 09/30/07</i>	D75	Coordination of Benefits has been applied.
		D81	The maximum benefit allowance under the non-duplication provisions is our normal benefit less the amount payable under the primary plan.
		F7	Charges paid in full by Medicare.
		781	The total benefit can not be more than the amount the plan would have paid had the plan been primary.
		80	The maximum benefit allowable under the non-duplication provision is our normal benefit less the amount payable under your primary plan.
		86	Primary insurance carrier has paid up to or more than the plan allowable amount. No further benefits are available.
24	Charges are covered under a capitation agreement/managed care plan.	None	
	<i>Active: 1/1/95. Modified: 6/30/00, 09/30/07</i>	I1	Capitation applied.

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25	Payment denied. The stoploss deductible has not been met. Active: 1/1/95 Deactivate: 4/1/08	None	
26	Expenses incurred prior to coverage. Active: 1/1/95	None >I >6 >9 S? SR S1	 The date of service is prior to the member's effective date. The date of service is before dependent effective date. The date of service is before signature date. The date of service is prior to the effective date of coverage. The date of service is prior to the patient's effective date. Plan was not effective on this date of service.
27	Expenses incurred after coverage terminated. Active: 1/1/95	None >L >O >2 >3 >4 >7 SM SO SQ	 Lapse in coverage. Benefit status shows no longer eligible. Group no longer eligible. Division no longer eligible. Member no longer eligible. Please check ID card. Spouse no longer eligible. Coverage is no longer in force. Member no longer eligible. Please check ID card. The patient is no longer eligible.
29	The time limit for filing has expired. Active: 1/1/95	None S5	 Timely-filing not met. Claim submitted after contract time limit.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. Active: 1/1/95 Deactivated: 2/1/06. Replaced by 177,178,179 & 180		
31	Patient cannot be identified as our insured. Active: 1/1/95 Modified: 09/30/07	None >? ># >B >D >E >F >G >P >V D72 MNF SB SD SL SN SP ST S7 22	 Eligibility not known. Group, division ID on CF member record unknown. Member and spouse only coverage. Member and child only coverage. Spouse and child only coverage. Spouse only coverage. Child only coverage. Eligibility information has not been received. Evidence of insurability failed. OEA's records reflect this patient is not covered. Please contact your school district. Patient not found. Please check ID card. Member and spouse only coverage. Member and children only coverage. Retirees are not covered. Patient is not eligible for benefits. Eligibility information has not been received. The patient is not eligible. Member is over maximum age. Our records indicate the patient eligibility is under a plan with dental coverage only.
32	Our records indicate that this dependent is not an eligible dependent as defined. Active: 1/1/95	None >A >S	 Overage dependent. Dependent student is no longer eligible.

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		>T	Benefit lapsed due to age options on GroupFacts BN record.
		>8	Dependent is not eligible.
		D71	OEA choice trust shows no proof of dependent status.
		S6	Dependent is over maximum age.
33	Insured has no dependent coverage. <i>Active: 1/1/95 Modified: 9/30/07</i>	None	
		>C	Member only coverage.
		SC	Member only coverage.
34	Insured has no coverage for newborns. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
35	Lifetime benefit maximum has been reached. <i>Active: 1/1/95 Last Modified: 10/31/02</i>	None	
		L2	Lifetime major medical maximum has been met. No further benefits are available.
38	Services not provided or authorized by designated (network/primary care) providers. <i>Active: 1/1/95 Last Modified: 6/30/03</i>	None	
		128	A referral by the Primary Care Physician (PCP) is required for a higher level of benefits.
		129	Use of an in-network provider is required for a higher level of benefits.
		130	A referral by the Primary Care Physician (PCP) is necessary to avoid denial of benefits.
		132	No benefits are allowable unless services are performed by an in-network provider.
		138	No record of a selected Primary Care Physician (PCP) on file. A referral by the PCP is required for a higher level of benefits.
		704	No benefits are allowable unless services are performed or referred by the primary care dentist.
39	Services denied at the time authorization/pre-certification was requested. <i>Active: 1/1/95</i>	None	
40	Charges do not meet qualifications for emergent/urgent care. <i>Active: 1/1/95</i>	None	
		103	Per medical record review, the service does not meet emergency room criteria. Benefit has been made for the assessment fee.
		105	Per medical record review, the service does not meet emergency room criteria. No benefits issued.
42	<i>Charges exceed our fee schedule or maximum allowable amount.</i> <i>Active: 1/1/95 Modified: 10/01/06. Deactivated 6/1/07</i>	None	
43	<i>Gramm-Rudman reduction.</i> <i>Active: 1/1/95 Deactivated: 7/1/06</i>		
44	Prompt-pay discount. <i>Active: 1/1/95</i>	None	
45	Charges exceed fee schedule / maximum allowable amount or contracted / legislated fee arrangement. <i>Active: 1/1/95. Last Modified: 10/31/06 (Change eff. 6/1/07)</i>	None	
		_E3	Provider discount has been applied.
		A1	Per diem discount has been applied.
		D04	Unable to determine benefits. Clinical information from provider was not received to substantiate necessity.
		EZ	Provider discount has been applied.
		E1	Provider discount has been applied.
		E3	Provider discount has been applied.

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		E7	Provider discount has been applied.
		E8	Provider discount has been applied.
		I0	This service is not covered. (CAP PROVIDER)
		R6	The charge exceeds the Delta amount allowed.
		R8	The charge exceeds the amount allowed.
		U04	The charge is in excess of the maximum plan allowance.
		W1	Provider discount has been applied.
		W6	The charge exceeds the amount allowed.
		W7	The charge exceeds the amount allowed.
		W8	The charge exceeds the amount allowed.
		23L	LET - provider discount has been applied.
		07D	The tooth surface(s) or area of oral cavity has been converted to match the procedure code submitted
		08D	The procedure code has been converted to match the tooth surface(s) or area of oral cavity submitted.
		39	Benefits are provided only for contracted services (CPT CODES). The patient is not responsible for the balance.
		54	Coverage based on Medicare allowed amount.
		55	This payment includes only the contracted per diem rate. The per diem excess charges have been processed separately.
		56	This payment represents the pass-thru benefit.
		66	This payment includes only the benefit for per diem excess charges. The contracted per diem allowance has been processed separately.
		92	The charge exceeds the amount by the Oregon Administrative Rule 436-0090020(1), bulletin 290, for Oregon Dept. of Corrections.
		112	Timely-filing not met by the provider. Claim submitted after contract time limit.
		121	Exceeds authorized length of stay. No medical necessity established for disallowed day(s).
		133	Negotiated package rates are all-inclusive. Provider is requested to contact the hospital regarding payment.
		135	No record of pre-authorization on file. No benefits can be allowed.
		13D	A comprehensive examination is limited to a periodic examination when performed by the same dentist or office within a three year period.
		145	PHCS provider discount has been applied.
		14D	The procedure code has been converted based on the surfaces billed.
		148	Sagamore provider discount has been applied.
		300	This is your DRG payment.
		401	Community Care Network (CCN) provider discount has been applied.
		502	Please resubmit with a valid code for reconsideration of benefits.
		504	provider type. Procedure is Status X (statutory exclusion) on CMS Physician Fee Schedule.
		506	Patient not liable for payment for this service. No indication that advance notice of non-coverage provided to patient as required.

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		507	Priced with covered G0101. For reconsideration, please send corrected claims using original Medicare's coding guidelines.
		711	The maximum number of x-rays payable for any one emergency is six.
		870	Lab pathology report is required.
		875	Clinical information requested to determine benefits. Please submit sufficient clinical evidence of necessity.
		9A7	Payment adjusted because requested information was not provided or was insufficient/incomplete.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. <i>Active: 1/1/95</i>	None	
50	These are non-covered services because this is not deemed a "medical necessity" by the payer. <i>Active: 1/1/95</i>		
		D79	Based on Consultant review, necessity not established.
		U13	The services rendered appear to be cosmetic in nature and not covered under the terms of the plan.
		05	No medical necessity indicated for this service or supply.
		05R	Benefits previously paid for this supply. No medical necessity indicated for replacement at this time.
		73F	Only charges for initial diagnostic services are covered. The plan excludes expense for treatment of this condition.
		950	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition. <i>Active: 1/1/95</i>	None	
		SY	Pre-existing conditions are not covered.
		18	Pre-existing condition not covered for period specified by the plan. The member has not provided credible coverage information.
52	<i>The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.</i> <i>Active: 1/1/95 Deactivated: 2/1/06. Replaced by 170, 183, 184 & 185.</i>	None	
53	Services by an immediate relative or a member of the same household are not covered. <i>Active: 1/1/95</i>	None	
54	Multiple physicians/assistants are not covered in this case. <i>Active: 1/1/95</i>	None	
		U15	The nature of this surgical procedure does not normally require the services of an assistant surgeon.
		TGA	The nature of this surgical procedure does not normally require the services of an assistant surgeon.
		954	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment is deemed experimental/investigational by the payer. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
		08	Experimental or investigational services and/or supplies are not covered.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	

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57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	None	
	Active: 1/1/95 Deactivated: 6/30/07 Split into codes 150, 151, 152, 153 and 154		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	None	
	Active: 1/1/95 Modified: 2/28/01, 09/30/07		
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia)	None	
	Active: 1/1/95 Modified: 2/28/07, 09/30/07		
60	Charges for outpatient services with this proximity to inpatient services are not covered.	None	
	Active: 1/1/95		
61	This change is to be effective 4/1/2008: penalty for failure to obtain second surgical opinion.	None	
	Active 1/1/95. Modified: 6/30/00, 09/30/07		
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	None	
	Active: 1/1/95 Last Modified: 10/31/06 Deactivated: 4/1/07		
66	Blood deductible.	None	
	Active: 1/1/95		
69	Day outlier amount.	None	
	Active: 1/1/95		
70	Cost outlier - Adjustment to compensate for additional costs.	None	
	Active: 1/1/95 Last Modified: 6/30/01	301	This is your outlier payment.
74	Indirect Medical Education Adjustment.	None	
	Active: 1/1/95		
75	Direct Medical Education Adjustment.		
	Active: 1/1/95	975	Direct medical education adjustment.
76	Disproportionate Share Adjustment.	None	
	Active: 1/1/95		
78	Non-covered days/room charge adjustment.	None	
	Active: 1/1/95	124	Plan allows up to semi-private room rate.
85	Interest amount.	None	
	Active: 1/1/95		
87	Transfer amount.		
	Active: 1/1/95	987	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.	None	
	Active: 1/1/95 To be Deactivated: 6/30/07		
89	Professional fees removed from charges.	None	
	Active: 1/1/95	989	Professional fees removed from charges.
90	Ingredient cost adjustment.	None	
	Active: 1/1/95		
91	Dispensing fee adjustment.	None	
	Active: 1/1/95	510	Denied for criteria not met; required related code (drug/supply/procedure code) must be billed on same claim.

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		511	Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame.
94	Processed in Excess of charges. <i>Active: 1/1/95</i>	None 006	This is the case rate/DRG payment.
95	Plan procedures not followed. <i>Active: 1/1/95</i> <i>Modified: 6/30/00, 09/30/07</i>	None AO DO	Adjudication override. Duplicate override.
		505	This service is only payable by Original Medicare. No allowance; for reporting purposes only under this member's plan.
96	Non-covered charge(s). This change to be effective 4/1/2007: 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 Modified: 6/30/06 Effective 4/1/07 a Remark Code must be provided.</i>	None >X	Benefit excluded for this patient.
		D01	Benefits are not provided for this type of service when filed on a predetermination.
		D09	Benefit is provided for fluoride once every six months up through the age of 18.
		D10	Benefit is provided for one examination, bitewing x-rays and one prophylaxis (including scaling and curettage) in each six month period.
		D11	Payment is provided for complete series x-rays (including panoramic) once in a three year period.
		D12	Payment for an examination fee includes the use of usual diagnostic aids, except for x-rays, study models and certain lab tests.
		D13	Payment is provided for study models for cases involving three or more missing teeth (not full dentures). Limited to one every five years.
		D16	Payment is provided for a single surface restoration in each episode of treatment regardless of the number of restorations placed.
		D31	No payment is provided for fixed bridges or removable cast partials for patients under the age of 16.
		D32	Payment is provided for stayplates, temporary partials, or temporary bridges only to replace recently extracted anterior teeth.
		D35	Our records indicate this tooth was previously extracted.
		D36	No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration otherwise.
		D41	Payment is provided for fixed bridge abutment restorations as part of the prosthetic benefit regardless of the condition of the abutment teeth.
		D56	Payment is provided for general anesthesia only in conjunction with covered surgical procedures performed in a dental office.
		D68	Payment is provided for desensitizing procedures only as an emergency procedure. Payment is not provided if done with any other treatment.
		D70	Payment is not provided for incomplete treatment. Please file on the completion date.
		D82	Appliances, restorations or procedures are not payable when done to increase vertical dimension.

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		D83	Appliances, restorations or procedures are not payable when done to treat, attrition, abrasion, erosion (wear) or restore occlusion.
		D84	Appliances, restorations or procedures are not payable when done to correct, congenital or developmental malformations.
		D85	Appliances, restorations or procedures are not payable when done to realign teeth.
		D86	Appliances, restorations or procedures are not payable when done to treat disturbances of the TMJ and associated structures.
		D87	Appliances, restorations or procedures are not payable when done for cosmetic reasons.
		D90	Appliances, restorations or procedures are not payable when done to correct habits.
		F0	Charges not allowed by Medicare.
		IR	Services on this tooth are not applicable for benefits.
		PE	Processed according to contract provisions.
		PM	This service is applicable to member only.
		PP	This service is applicable to member and spouse only.
		RK	This service is applicable to member and children only.
		RL	This service is applicable to spouse and children only.
		RM	This service is applicable to member only.
		RP	This service is applicable to member and spouse only.
		RR	Services on this tooth are not applicable for benefits.
		RS	This service is applicable to spouse only.
		WR	Services on this tooth are not applicable for benefits.
		YC	This service is applicable to children only.
		YK	This service is applicable to member and children only.
		YL	This service is applicable to spouse and children only.
		YM	This service is applicable to member only.
		YP	This service is applicable to member and spouse only.
		YR	Services on this tooth are not applicable for benefits.
		YS	This service is applicable to spouse only.
		03D	Full mouth debridement is not covered if performed within 24 months of a prophylaxis or periodontal maintenance procedure.
		30	Processed according to contract limitations.
		33	Please submit a complete itemization of services, including medical diagnosis, description and charge for each service.
		73	Only charges for initial diagnostic services are covered. The plan excludes expense for treatment of this condition.
		110	A signed, valid consent form required. Please submit with claim.
		122	The plan allows preventive health care benefits only when services are provided by the primary care physician (PCP).
		141	The service is not covered. Our records indicate another provider is the primary chemical dependency provider for this service.
		144	The diagnosis and treatment pair is below the line as defined on the prioritized list of covered services.
		540	Coverage based on Medicare allowed amount.

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		628	Replacement of stainless steel crowns are not covered if performed within twenty four months of the initial placement.
		653	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.
		670	Lab pathology report is required.
		732	Payment is provided for stayplates or temporary partials only to replace recently extracted anterior teeth.
		744	Replacement of a space maintainer is not a covered benefit when lost, stolen or damaged.
		845	A comprehensive periodontal examination is limited to a periodic examination when performed the same day as periodontal maintenance.
		998	Payment adjusted due to Medicare's change in fee schedule or maximum allowable amount.
97	The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated.	None	
	<i>Active: 1/1/95 Modified: 10/31/06, 09/30/07</i>	D02	Retreatment of root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment fee.
		D06	Allowance for this procedure is included in other services on this predetermination, claim, same day and/or the same tooth.
		D07	Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee.
		D19	Preparation of gingival tissue for placing a crown should be included in the fee for the crown.
		D20	A separate, additional payment is not provided for tooth preparation, temporary treatment, bases, impressions or local anesthesia.
		D21	Payment is provided for pulp capping when there is exposure of the pulp. We do not pre-determine this expense.
		D37	Reline is included in the amount of payment provided for the complete replacement of a denture base (jump) fee.
		D47	A separate, additional payment is not provided for denture adjustment and post-op care done within six months after initial placement.
		D55	Payment for root canal(s) includes cultures, necessary x-rays (other than initial exam x-rays), pulpotomies and post-operative care.
		D59	Allowance for this procedure is included in other services on this predetermination, claim, same day and/or the same tooth.
		D67	A separate, additional payment is not provided for alveolectomies done in conjunction with the surgical removal of teeth.
		D69	Post-operative visits are considered a part of the complete procedure. No extra payment is provided.
		D88	Based on Consultant review, necessity not established. Treatment is considered part of the restoration.
		TGB	Service is considered included in the payment for the primary CPT code.
		TGC	Multiple CPT codes have been combined into one code that describes all the services.
		TGD	Physician visits are considered part of the surgical service.
		TGE	Service is included in the payment for the physician visit code.
		TGF	Only one visit/evaluation and management code is allowed per date of service.

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		TGG	Payment for immunizations includes payment for the injection.
		TGH	Payment for lab services include blood drawing and/or specimen collection fees.
		TGI	Procedure code billed more than once for the same day, and appears to be a duplicate billing for the same service.
		TGL	This procedure code is only eligible to be billed once per day. Additional units for the same day are included.
		TGM	This procedure code is only eligible to be billed once per month.
		TGN	This procedure code is only eligible to be billed once per week.
		TGO	This service or supply is included in the payment for another service billed on the same day.
		U02	The charges for this procedure have been considered as part of the primary procedure.
		U03	The charges for this procedure have been considered as part of the primary procedure.
		U22	This service is normally included in the cost of the surgical procedure.
		U23	This procedure is normally included in the cost of the primary procedure.
		U24	This procedure is normally included in the cost of the primary procedure when performed on the same day.
		U31	The charges for this procedure have been combined with those of the primary procedure.
		77	Benefits for miscellaneous charges are included in the payment for the base rate.
		12D	The procedure code has been converted due to the patient's age.
		16D	Replacement of a sealant within 24 months of the initial placement the change will be a provider discount.
		503	No separate payment can be made for this service. This is a Medicare bundled/excluded code.
		690	A separate, additional payment is not provided for repair or relines done within six months after initial placement of occlusal guard.
		713	Payment for some or all multiple x-rays of the same tooth or area may be denied if determined the number is excessive.
		721	All surfaces must be combined and billed, one line per tooth, using the appropriate code.
		722	Payment for an amalgam or composite restoration and a crown on the same tooth is not a benefit.
		812	The procedure code has been converted due to the patient's age.
		816	Replacement of a sealant within 24 months of the initial placement the change will be a provider discount.
		820	A separate, additional payment is not provided for tooth preparation, temporary treatment, bases, impressions or local anesthesia.
		828	Replacement of stainless steel crowns are not covered if performed within twenty four months of the initial placement.
		832	Retreatment of root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment fee.
		853	Benefits are not provided for tissue conditioning if performed on the same day a denture is delivered or a reline/rebase is provided.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		869	Post-operative visits are considered a part of the complete procedure. No extra payment is provided.
		890	A separate, additional payment is not provided for repair or relines done within six months after initial placement of occlusal guard.
		997	Payment is included in the allowance for another service/procedure.
100	Payment made to patient/insured/responsible party. <i>Active: 1/1/95</i>	None	
101	Predetermination: anticipated payment upon completion of services or claim adjudication. <i>Active: 1/1/95 Last Modified: 2/28/99</i>	None	
		09D	Treatment plan 1.
		10D	Treatment plan 2.
102	Major Medical Adjustment. <i>Active: 1/1/95</i>	None	
103	Provider promotional discount (i.e. Senior citizen discount). <i>Active: 1/1/95 Last Modified: 6/30/01</i>	None	
104	Managed care withholding. <i>Active: 1/1/95</i>	None	
105	Tax withholding. <i>Active: 1/1/95</i>	None	
106	Patient payment option/election not in effect. <i>Active: 1/1/95</i>	None	
107	The related or qualifying claim/service was not identified on the claim. <i>Active: 1/1/95 Modified: 10/31/06, 09/30/07</i>	None	
		TGJ	The procedure (add-on) code is not allowed separately. The required primary code was not billed for the same date of service.
108	Payment adjusted because rent/purchase guidelines were not met. <i>Active: 1/1/95 Last Modified: 6/30/02</i>	None	
		89	The plan covers rental (not to exceed the reasonable purchase price) of medically necessary durable medical equipment.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. <i>Active: 1/1/95</i>	None	
		108	This plan has terminated. Please submit the claim to the new insurance carrier.
		400	Provider is requested to submit claim to Valueoptions: PO Box 1290, Latham, NY 12110. For more information call 1-800-892-8804.
		508	Part D service. Please bill patient.
110	Billing date predates service date. <i>Active: 1/1/95</i>	None	
111	Not covered unless the provider accepts assignment. <i>Active: 1/1/95</i>	None	
112	Service not furnished directly to the patient and/or not documented. <i>Active: 1/1/95 Modified: 09/30/07</i>	None	
113	<i>Payment denied because service/procedure was provided outside the United States or as a result of war.</i> <i>Active: 1/1/95 Deactivated: 6/30/07. Replaced by 157, 158 or 159.</i>	None	
114	Procedure/product not approved by the Food and Drug Administration.	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
	Active: 1/1/95		
115	Procedure postponed, canceled or delayed. Active: 1/1/95 Modified: 2/28/01, 09/30/07	None	
116	The advance indemnification notice signed by the patient did not comply with requirements. Active: 1/1/95 Modified: 2/28/01, 09/30/07	None	
117	Transportation is only covered to the closest facility that can provide the necessary care. Active: 1/1/95 Modified: 2/28/01, 09/30/07	None	
118	ESRD network support adjustment. Active: 1/1/95 Modified: 09/30/07	None	
119	Benefit maximum for this time period has been reached. Active: 1/1/95 Last Modified: 2/29/04	None	
		BX	Vision benefit limit has been reached.
		B1	Vision benefit limit has been reached.
		B2	Vision benefit limit has been reached.
		B3	Vision benefit limit has been reached.
		B4	The maximum allowed for services of this type has been reached.
		B5	The maximum allowed for services of this type has been reached.
		D24	Payment is provided for a full mouth x-ray (including panoramic) once in a two year period.
		D25	Family maximum has been met for this benefit year.
		D27	Payment is provided for cast restorations and porcelain crowns once in a three year period.
		D28	Benefit is provided for one periodontal recall visit once in a three month period.
		D29	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a five year period.
		D33	Payment is provided for prosthetic appliances once in a five year period.
		D38	Payment is provided for relines, including conditioners, once in a twelve month period.
		D39	Benefit is provided for one rebase in each twelve month period.
		D45	Payment is provided for relines, including conditioners, once in a six month period.
		D51	Benefits are provided for sealants on permanent molars and bicuspid once every five years.
		D52	Payment is provided for cast restorations, porcelain crowns and/or a prosthetic device once in a seven year period.
		D60	Benefit is provided for topical fluoride once in each six month period.
		D95	Treatment has been paid in full. No additional benefit can be issued.
		D96	Benefits have been prorated. The final payment was issued previously.
		ET	The maximum allowed for services of this type has been reached.
		E4	The maximum allowed for services of this type has been reached.
		E5	The maximum allowed for services of this type has been reached.
		I5	The maximum allowed for services of this type has been reached.
		JT	The maximum allowed for services of this type has been reached.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		J4	The maximum allowed for services of this type has been reached.
		J5	The maximum allowed for services of this type has been reached.
		L7	Maximum has been met for this benefit period.
		L9	Class III maximum benefit has been met for this benefit year.
		L1A	The maximum has been met for this type of durable medical equipment, including related services and supplies.
		L10	Maximum has been met for these services. No further benefits are available.
		L11	The maximum has been met for durable medical equipment and/or supplies.
		L13	Preventive health care maximum has been met for this benefit period.
		L14	Vision service maximum has been met for this benefit period.
		L15	Chiropractic service maximum has been met for this benefit period.
		L16	Naturopathic service maximum has been met for this benefit period.
		L17	Acupuncture service maximum has been met for this benefit period.
		L25	Maximum benefit has been met for this benefit year.
		L26	Orthodontic maximum has been met for this benefit year.
		L27	TMJ maximum has been met for this benefit year.
		L28	Periodontal maximum has been met for this benefit year.
		L29	Family maximum has been met for this benefit year.
		P4	The maximum allowed for services of this type has been reached.
		P5	The maximum allowed for services of this type has been reached.
		R4	The maximum allowed for services of this type has been reached.
		R5	The maximum allowed for services of this type has been reached.
		W5	The maximum allowed for services of this type has been reached.
		Y4	The maximum allowed for services of this type has been reached.
		Y5	The maximum allowed for services of this type has been reached.
		04D	Orthodontic maximum has been met for this benefit period.
		05D	Payment is provided for removable complete dentures, removable partial dentures and/or fixed partial dentures once each 10 years.
		13	Benefit limit of one such service in 12 consecutive months.
		14	Benefit limit of one such service in 24 consecutive months.
		18D	This service is limited to once per lifetime per tooth space.
		45	Inpatient maximum for this condition has been reached.
		28	The \$50.00 maximum benefit for prenatal/child birthing classes has been met. Patient responsibility applied.
		79	Maximum benefit has been reached for this type of service.
120	Patient is covered by a managed care plan.	None	
	Active: 1/1/95 Deactivate: 6/30/07 Use code 24		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
121	Indemnification adjustment. <i>Active: 1/1/95</i>	None	
122	Psychiatric reduction. <i>Active: 1/1/95</i>	None	
123	Payer refund due to overpayment. <i>Active: 1/1/95 Deactivate: 6/30/07</i>	None	
124	Payer refund amount - not our patient. <i>Active: 1/1/95 Last Modified: 6/30/99 Deactivate: 6/30/07</i>	None	
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either Remittance Advice Remark Code or NCPDP Reject Reason Code) <i>Active: 1/1/95 Modified: 6/30/06, 09/30/07 Effective 4/1/07 a Remark Code must be provided.</i>	None	
		D00	A non ADA or incorrect code has been used. The provider is requested to re-submit a claim with the appropriate ADA CDT code.
		D97	Please re-submit with the appropriate ADA code, clinical information, and reason for placement.
		40	Please re-submit with HCPCS code for each item included in procedure 99070.
		91	Adjustment due to additional billing. This change does not affect benefits which have already been issued.
		109	Please re-submit with a diagnosis.
		117	Re-submit with a valid CPT/HCPCS code.
126	Deductible -- Major Medical <i>Active: 2/28/97</i>	None	
127	Coinsurance -- Major Medical <i>Active: 2/28/97</i>	None	
128	Newborn's services are covered in the mother's Allowance. <i>Active: 2/28/97</i>	None	
129	Prior processing information appears incorrect. <i>Active: 2/28/97 Modified: 2/28/01, 09/30/07</i>	None	
130	Claim submission fee. <i>Active: 2/28/97 Last Modified: 6/30/01</i>	None	
		D03	A separate fee for completion of a claim form is not covered.
131	Claim specific negotiated discount. <i>Active: 2/28/97</i>	None	
		T01	Paid according to your PPO contract with NPPN/PIPA.
		T02	Paid according to your PPO contract with NPPN/Family Chiropractic America.
		T03	Paid according to your PPO contract with NPPN/Carrington International Group.
		T04	Paid according to your PPO contract with NPPN/PPOIN.
		T05	Paid according to your PPO contract with NPPN/OHIO Preferred Network.
		T06	Paid according to your PPO contract with NPPN/Interplan.
		T07	Paid according to your PPO contract with NPPN/Beltone.
		T08	Paid according to your PPO contract with NPPN/Dahlberg Miracle Ear.
		T09	Paid according to your PPO contract with NPPN/First Choice Healthplan of MS.
		T10	Paid according to your PPO contract with NPPN/PPOKY.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T11	Paid according to your PPO contract with NPPN/CHN/CT.
		T12	Paid according to your PPO contract with NPPN/HCN - WI/Multiplan.
		T13	Paid according to your PPO contract with NPPN/First Choice Network.
		T14	Paid according to your PPO contract with NPPN/Select PPO.
		T15	Paid according to your PPO contract with NPPN/HCVM.
		T16	Paid according to your PPO contract with NPPN/AHI/Healthlink.
		T17	Paid according to your PPO contract with NPPN/Physicians Network.
		T18	Paid according to your PPO contract with NPPN/Henry Ford Health System.
		T19	Paid according to your PPO contract with NPPN/FCM.
		T1A	Paid according to your PPO contract with NPPN/HPO/LTD.
		T1B	Paid according to your PPO contract with NPPN/HPO/MHN.
		T1C	Paid according to your PPO contract with NPPN/HPO/MMP.
		T1D	Paid according to your PPO contract with NPPN/HPO/PHS.
		T1E	Paid according to your PPO contract with TRPN/ACS.
		T1F	Paid according to your PPO contract with NPPN/Buckeye Network.
		T1G	Paid according to your PPO contract with TRPN/CMN.
		T1H	Paid according to your PPO contract with TRPN/CCN.
		T1I	Paid according to your PPO contract with TRPN/IMS.
		T1J	Paid according to your PPO contract with Wellington Health.
		T1K	Paid according to your PPO contract with American/Caresource.
		T1L	Paid according to your PPO contract with NPPN/TRPN/Primary Health Services.
		T1M	Paid according to your PPO contract with NPPN/TRPN/PHS/First Choice MS.
		T1N	Paid according to your PPO contract with NPPN/TRPN/PrimaryHlt-Logicomp.
		T1O	Paid according to your PPO contract with NPPN/TRPN/PHS-Hlthcare-MT States.
		T1P	Paid according to your PPO contract with NPPN/TRPN/Primary Hlth Sv-Plus.
		T1Q	Paid according to your PPO contract with NPPN/TRPN/Primary Hlth-Comp Results.
		T1R	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Comp Trac.
		T1S	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Wrk Part.
		T1T	Paid according to your PPO contract with NPPN/TRPN/PHS-TN Hlthcare Worxs.
		T1U	Paid according to your PPO contract with NPPN/TRPN/Quality Partnership.
		T1V	Paid according to your PPO contract with Medical Resource 800.543.5260.
		T1W	Paid according to your PPO contract with MR/American Care Source
		T1X	Paid according to your PPO contract with MR/American Health Resources Network.
		T1Y	Paid according to your PPO contract with MR/California Foundation for Medical Care.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T1Z	Paid according to your PPO contract with MR/National Hospital Network.
		T20	Paid according to your PPO contract with NPPN/ABPA/ProHealth.
		T21	Paid according to your PPO contract with NPPN/HPO/IHP.
		T22	Paid according to your PPO contract with NPPN/Baycare.
		T23	Paid according to your PPO contract with NPPN/Intergroup.
		T24	Paid according to your PPO contract with NPPN/Community Health Partners.
		T25	Paid according to your PPO contract with NPPN/Association of Primary Care Physicians.
		T26	Paid according to your PPO contract with NPPN/Columbia HCA North Texas Division.
		T27	Paid according to your PPO contract with NPPN/Universal/NV.
		T28	Paid according to your PPO contract with INNPPN/TRPN.
		T29	Paid according to your PPO contract with NPPN/American Care Source.
		T2A	Paid according to your PPO contract with MR/National Provider Network.
		T2B	Paid according to your PPO contract with MR/ppoNEXT.
		T2C	Paid according to your PPO contract with MR/Prime Health Services.
		T2D	Paid according to your PPO contract with MR/Provider Select Inc.
		T2E	Paid according to your PPO contract with MR/The Health Payors Organization
		T2F	Paid according to your PPO contract with NPPN/American PPO
		T2G	Paid according to your PPO contract with NPPN/Independent Medical System..
		T2H	Paid according to your PPO contract with NPPN/TRPN/ASPA
		T2I	Paid according to your PPO contract with TRPN/ARAZ
		T2J	Paid according to your PPO contract with TRPN/CFMC
		T2K	Paid according to your PPO contract with TRPN/Consumer Health Network
		T2L	Paid according to your PPO contract with TRPN/Dimension.
		T2M	Paid according to your PPO contract with TRPN/Family Health America.
		T2N	Paid according to your PPO contract with TRPN/Fortified Provider Network.
		T2O	Paid according to your PPO contract with TRPN/HFN.
		T2P	Paid according to your PPO contract with TRPN/Integrated Health Plan.
		T2Q	Paid according to your PPO contract with TRPN/Managed Care Strategies.
		T2R	Paid according to your PPO contract with TRPN/National Provider Network.
		T2S	Paid according to your PPO contract with TRPN/Ohio Preferred Network.
		T2T	Paid according to your PPO contract with TRPN/Preferred Mental Health Network.
		T2U	Paid according to your PPO contract with TRPN/Prime Health Services.
		T2V	Paid according to your PPO contract with TRPN/Quality Healthcare Partnership.
		T2W	Paid according to your PPO contract with TRPN/Universal Health Network..

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T2X	Paid according to your PPO contract with Three Rivers Provider Network (TRPN).
		T2Y	Paid according to your PPO contract with TRPN/Initial Group.
		T2Z	Paid according to your PPO contract with TRPN/FCHN.
		T30	Paid according to your PPO contract with NPPN/Healthcare Network of America.
		T31	Paid according to your PPO contract with NPPN/PCC PPO.
		T32	Paid according to your PPO contract with NPPN/MRI.
		T33	Paid according to your PPO contract with NPPN/MRI/National Hospital Network.
		T34	Paid according to your PPO contract with NPPN/MRI/National Provider Network.
		T35	Paid according to your PPO contract with NPPN/MRI/Provider Strategies Inc.
		T36	Paid according to your PPO contract with NPPN/MRI/Galaxy Health Network.
		T37	Paid according to your PPO contract with NPPN/Health Management.
		T38	Paid according to your PPO contract with NPPN/Rural Arizona.
		T39	Paid according to your PPO contract with NPPN/Arizona Medical Network.
		T3A	Paid according to your PPO contract with NPPN/TRPN/Premium Health.
		T3B	Paid according to your PPO contract with TRPN/MCS/ppoNEXT.
		T3C	Paid according to your PPO contract with Ohio Preferred Network.
		T3D	Paid according to your PPO contract with Intergroup.
		T3E	Paid according to your PPO contract with MR/Fortified Provider Network.
		T3F	Paid according to your PPO contract with MR/HPO/IHP.
		T3G	Paid according to your PPO contract with MR/HPO/MHN.
		T3H	Paid according to your PPO contract with MR/HPO/MMPP.
		T3I	Paid according to your PPO contract with NPPN/Preferred Mental Health Network.
		T3J	Paid according to your PPO contract with Beech Street AP Network.
		T3K	Paid according to your PPO contract with NPPN/Medlink Health Network.
		T3L	Paid according to your PPO contract with NPPN/Fortified Provider Network.
		T3M	Paid according to your PPO contract with NPPN/MRI/NPN/Premier Care.
		T3N	Paid according to your PPO contract with NPPN/MRI/NPN/Medical Network of Colorado Springs.
		T3O	Paid according to your PPO contract with NPPN/Interplan/TX.
		T3P	Paid according to your PPO contract with NPPN/Baptist Health Services Group.
		T3Q	Paid according to your PPO contract with NPPN/Lee Physician Hospital Organization.
		T3R	Paid according to your PPO contract with NPPN/Medical Care Referral Group.
		T3S	Paid according to your PPO contract with NPPN/MRI/Prime Health Service.
		T3T	Paid according to your PPO contract with MR/Medical Care Referral Group (MCRG).

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T3U	Paid according to your PPO contract with HPO/Arizona Medical Network.
		T3V	Paid according to your PPO contract with HPO/Health Management Network.
		T3W	Paid according to your PPO contract with Health Payors Organization (HPO)
		T3X	Paid according to your PPO contract with HPO/Competitive Health Network.
		T3Y	Paid according to your PPO contract with HPO/Integrated Health Plan.
		T3Z	Paid according to your PPO contract with Interplan Health Group.
		T40	Paid according to your PPO contract with NPPN/Novanet.
		T41	Paid according to your PPO contract with NPPN/Mayan PPO.
		T42	Paid according to your PPO contract with NPPN/Healthpoint.
		T43	Paid according to your PPO contract with NPPN/Susquehanna Health Care.
		T44	Paid according to your PPO contract with NPPN/Signature (Nashville).
		T45	Paid according to your PPO contract with NPPN/Universal/LA.
		T46	Paid according to your PPO contract with NPPN/PPONext FKA Preferred Health Network.
		T47	Paid according to your PPO contract with NPPN/Healthspan.
		T48	Paid according to your PPO contract with NPPN/Dimension.
		T49	Paid according to your PPO contract with NPPN/The Initial Group.
		T4A	Paid according to your PPO contract with HPO/Integrated Health Plan/FPN.
		T4B	Paid according to your PPO contract with HPO/Integrated Health Plan/NHP.
		T4C	Paid according to your PPO contract with HPO/Managed Healthcare Northwest.
		T4D	Paid according to your PPO contract with HPO/Rural Arizona Network.
		T4E	Paid according to your PPO contract with NPPN/Genesis Physician Group.
		T4F	Paid according to your PPO contract with Devon Network.
		T4G	Paid according to your PPO contract with HFN-ID Network.
		T4H	Paid according to your PPO contract with AMN Network.
		T4I	Paid according to your PPO contract with FPN Network.
		T4J	Paid according to your PPO contract with HMN Network.
		T4K	Paid according to your PPO contract with RAN Network.
		T4L	Paid according to your PPO contract with NPPN/Global Health Claim Service Network.
		T4M	Paid according to your PPO contract with Galaxy/Managed Care Inc.
		T4N	Paid according to your PPO contract with Plan Care America.
		T4O	Paid according to your PPO contract with Coalition America.
		T4P	Paid according to your PPO contract with Integrated Health Plan, Inc.
		T4Q	Paid according to your PPO contract with IHP/Community Health Alliance.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T4R	Paid according to your PPO contract with IHP/FHN Health Network.
		T4S	Paid according to your PPO contract with IHP/Flora Health Network.
		T4T	Paid according to your PPO contract with IHP/Fortified Provider Network.
		T4U	Paid according to your PPO contract with IHP/Galaxy Health Network.
		T4V	Paid according to your PPO contract with IHP/Health First Network.
		T4W	Paid according to your PPO contract with IHP/Health Care Network of America.
		T4X	Paid according to your PPO contract with IHP/Medical Care Referral Group.
		T4Y	Paid according to your PPO contract with IHP/Medical Resources.
		T4Z	Paid according to your PPO contract with IHP/National Hospital Network.
		T50	Paid according to your PPO contract with NPPN/Dimension/Tenet.
		T51	Paid according to your PPO contract with NPPN/MH Net.
		T52	Paid according to your PPO contract with NPPN/Virginia Health Network.
		T53	Paid according to your PPO contract with NPPN/QualChoice of Arkansas.
		T54	Paid according to your PPO contract with NPPN/First Choice Health/Sound Health.
		T55	Paid according to your PPO contract with NPPN/MedicalControl.
		T56	Paid according to your PPO contract with NPPN/Direct.
		T57	Paid according to your PPO contract with NPPN/CS-Direct.
		T58	Paid according to your PPO contract with NPPN/HFN.
		T59	Paid according to your PPO contract with NPPN/Heartland.
		T5A	Paid according to your PPO contract with IHP/National Provider Network.
		T5B	Paid according to your PPO contract with IHP/NPN Indiana Pro Health Network.
		T5C	Paid according to your PPO contract with IHP/NPN Medical Network of Colorado Springs.
		T5D	Paid according to your PPO contract with IHP/NPN Premier Care.
		T5E	Paid according to your PPO contract with IHP/Preferred Care.
		T5F	Paid according to your PPO contract with IHP/Preferred Care - Aiken SC.
		T5G	Paid according to your PPO contract with IHP/Prime Health Services Inc.
		T5H	Paid according to your PPO contract with IHP/ Provider Select Inc.
		T5I	Paid according to your PPO contract with IHP/ TLC Advantage.
		T60	Paid according to your PPO contract with NPPN/CHN/NJ.
		T61	Paid according to your PPO contract with Evolutions Healthcare Systems.
		T62	Paid according to your PPO contract with FIPA/NAMM/PHYCOR Group.
		T63	Paid according to your PPO contract with EHS/HPO Limited.
		T64	Paid according to your PPO contract with EHS/Interplan.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		T65	Paid according to your PPO contract with EHS/Intergroup.
		T66	Paid according to your PPO contract negotiated agreement.
		T67	Paid according to your PPO contract with EHS/Managed Care of America.
		T68	Paid according to your PPO contract with EHS/Galaxy.
		T69	Paid according to your PPO contract with EHS/Medical Resource.
		T70	Paid according to your PPO contract with EHS/PPONext.
		T71	Paid according to your PPO contract with Post Acute Care.
		T72	Paid according to your PPO contract with EHS/TRPN/HPO.
		T73	Paid according to your PPO contract negotiated agreement.
		T74	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica.
		T75	Paid according to your PPO contract with Emergis/UP&UP/ProAmerica (Shared Savings).
		T76	Paid according to your PPO contract with NCN/Multiplan.
		T77	Paid according to your PPO contract with NCN/American Care Source (ACS).
		T78	Paid according to your PPO contract with Concentra/Multiplan.
		T79	Paid according to your PPO contract with NPPN/Healthcare Direct.
		T80	Paid according to your PPO contract with NPPN/InterWest Health.
		T81	Paid according to your PPO contract with NPPN/America's PPO.
		T83	Paid according to your PPO contract with NPPN/Accountable Health Plans.
		T84	Paid according to your PPO contract with NPPN/PPOIN/ProHealth.
		T85	Paid according to your PPO contract with NPPN/PPONext.
		T86	Paid according to your PPO contract with NPPN/TRPN-FPN.
		T87	Paid according to your PPO contract with NPPN/TRPN-QHP.
		T88	Paid according to your PPO contract with PPONext.
		T89	Paid according to your PPO contract with Multiplan.
		T90	Paid according to your PPO contract with NPPN/TRPN/MCS.
		T91	Paid according to your PPO contract with NPPN/TRPN/Preferred Mental Health Management.
		T92	Paid according to your PPO contract with NPPN/TRPN/CFMC.
		T94	Paid according to your PPO contract with NPPN/HPO/FPN.
		T95	Paid according to your PPO contract with NPPN/HPO/IHP/NHP.
		T96	Paid according to your PPO contract with NPPN/HPO/CHP.
		T97	Paid according to your PPO contract with NPPN/HPO/CHP/PHA.
		T98	Paid according to your PPO contract with NPPN/HPO/HCP.
		T99	Paid according to your PPO contract with NPPN/HPO/LTD.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		120	The allowance was based on a negotiated rate. The patient is not responsible for the discounted amount.
132	Prearranged demonstration project adjustment. <i>Active: 2/28/97</i>	None	
133	The disposition of this claim/service is pending further review. <i>Active: 2/28/97 Last Modified: 10/31/99</i>	None	
		52	Pending hospital audit.
134	Technical fees removed from charges. <i>Active: 10/31/98</i>	None	
135	Interim bills cannot be processed. <i>Active: 10/31/98 Modified: 09/30/07</i>	None	
		D98	Additional orthodontic billings are not required. Payments are issued automatically according to the plans payment schedule.
		19	Benefits cannot be considered until OB care has been completed. Please submit claim at that time.
136	Failure to follow prior payer's coverage rules. (Use Group Code OA) <i>Active: 10/31/98 Modified: 10/31/06, 09/30/07</i>	None	
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. <i>Active: 2/28/99 Modified: 09/30/07</i>	None	
138	Appeal procedures not followed or time limits not met. <i>Active: 6/30/99 Modified: 09/30/07</i>	None	
		H38	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services. <i>Active: 6/30/99</i>	None	
140	Patient/Insured health identification number and name do not match. <i>Active: 6/30/99</i>	None	
141	Claim spans eligible and ineligible periods of coverage. <i>Active: 6/30/99 Modified: 6/30/00, 09/30/07</i>	None	
142	Monthly Medicaid patient liability amount. <i>Active: 6/30/00 Modified: 09/30/07</i>	None	
143	Portion of payment deferred. <i>Active: 2/28/01</i>	None	
144	Incentive adjustment, e.g. preferred product/service. <i>Active: 6/30/01</i>	None	
145	Premium payment withholding. <i>Active: 6/30/02</i>	None	
146	Diagnosis was invalid for the date(s) of service reported. <i>Active: 6/30/02 Modified: 09/30/07</i>	None	
147	Provider contracted/negotiated rate expired or not on file. <i>Active: 6/30/02</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
148	Information from another provider was not provided or was insufficient/incomplete. <i>Active: 6/30/02 Modified: 09/30/07</i>	None	
149	Lifetime benefit maximum has been reached for this service/benefit category. <i>Active: 10/31/02</i>	None	
		L8	Lifetime maximum for transplantation related expenses has been met.
		L12	TMJ service maximum has been met.
		L33	Periodontal lifetime maximum has been met.
		L34	TMJ lifetime maximum has been met.
		L35	Orthodontic lifetime maximum has been met.
150	Payer deems the information submitted does not support this level of service. <i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	None	
		D46	Benefit limited. No history of nonsurgical therapy.
		D64	Please re-evaluate necessity after periodontal scaling and root planning has been performed/completed.
		D89	Based on consultant review, benefit is limited.
		857	Benefit limited. No history of periodontal treatment.
151	Payer deems the information submitted does not support this many services. <i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	None	
152	Payer deems the information submitted does not support this length of service. <i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	None	
153	Payer deems the information submitted does not support this dosage. <i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	None	
154	Payer deems the information submitted does not support this day's supply. <i>Active: 10/31/02. Previously under ARC 57. Modified: 09/30/07</i>	None	
155	Patient refused the service/procedure. <i>Active: 6/30/03 Modified: 09/30/07</i>	None	
156	Flexible spending account payments. <i>Active: 9/30/03</i>	None	
157	Service/procedure was provided as a result of an act of war. <i>Active: 9/30/03 Previously under ARC 113. Modified: 09/30/07</i>	None	
158	Service/procedure was provided outside of the United States. <i>Active: 9/30/03. Previously under ARC 113. Modified: 09/30/07</i>	None	
159	Service/procedure was provided as a result of terrorism. <i>Active: 9/30/03. Previously under ARC 113. Modified: 09/30/07</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
160	Injury/illness was the result of an activity that is a benefit exclusion. <i>Active: 9/30/03 Modified: 09/30/07</i>	None	
161	Provider performance bonus. <i>Active: 2/29/04</i>	None	
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. <i>Active: 2/29/04</i>	None	
163	Attachment referenced on the claim was not received. <i>Active: 6/30/04 Modified: 09/30/07</i>	None	
164	Attachment referenced on the claim was not received in a timely fashion. <i>Active: 6/30/04 Modified: 09/30/07</i>	None	
165	Referral absent or exceeded. <i>Active: 10/31/04 Modified: 09/30/07</i>	None	
166	These services were submitted after this payers responsibility for processing claims under this plan ended. <i>Active: 2/28/05</i>	None 15D	Effective 6/1/07 Orthodontic claims are processed by WDS. This claim has been forwarded to WDS.
167	This (these) diagnosis(es) is (are) not covered. <i>Active: 6/30/05</i>	None 34	Treatment for this diagnosis is not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. <i>Active: 02/01/06 Modified: 09/30/07</i>	None	
169	Alternate benefit has been provided. <i>Active: 02/01/06 Modified: 09/30/07</i>	None D17 D18 D23 D40 D42 D43 D50 D92 D94	If tooth can be restored with a material such as amalgam or composite, payment will be based on the allowable for amalgam or composite. Tooth colored (composite) fillings on back teeth are not a benefit. Allowance has been made for a silver (amalgam) filling. Porcelain crowns, if posterior to the upper first molar and the lower second bicuspid, are optional. Benefits is for a full gold crown. An alternative benefit has been provided based on the contract limitation. Payment is not provided for transitional dentures, treatment dentures, or temporary dentures. Reline benefit is provided. Overdentures are allowed based on the fee for a standard denture plus allowance for root canal therapy for overdenture. Root canals on deciduous teeth are allowed as pulpotomies unless the permanent tooth is missing. Porcelain/resin onlays on posterior teeth are optional. Benefit is provided for a metallic onlay. Benefit has been provided for an alternate procedure.
170	Payment is denied when performed/billed by this type of provider <i>Active: 6/30/05</i>	None D05 31	Payment is provided only for charges by a licensed dentist. This type of provider is not covered.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		62	The provider is not covered or working in a state approved program.
		98	This service is not covered when performed by this type of provider.
		705	This service is not covered. The attending dentist does not participate in the ODS/Oregon Health Plan.
171	Payment is denied when performed/billed by this type of provider in this type of facility. <i>Active: 6/30/05</i>	None	
172	Payment is adjusted when performed/billed by a provider of this specialty. <i>Active: 6/30/05</i>	None	
173	Service was not prescribed by a physician. <i>Active: 02/01/06 Modified: 09/30/07</i>	None	
174	Service was not prescribed prior to delivery. <i>Active: 02/01/06. Previously under ARC B17. Modified: 09/30/07</i>	None	
175	Prescription is incomplete. <i>Active: 02/01/06. Previously under ARC B17. Modified: 09/30/07</i>	None	
176	Prescription is not current. <i>Active: 02/01/06. Previously under ARC B17. Modified: 09/30/07</i>	None	
177	Patient has not met the required eligibility requirements. <i>Active: 02/01/06. Previously under ARC 30 Modified: 09/30/07</i>	None	
178	Patient has not met the required spend down requirements. <i>Active: 02/01/06. Previously under ARC 30 Modified: 09/30/07</i>	None	
179	Patient has not met the required waiting requirements. <i>Active: 02/01/06. Previously under ARC 30. Modified: 09/30/07</i>	>5	The date of service is during waiting period.
		37	No benefits can be paid for services related to this condition/procedure during the first six months of coverage.
180	Patient has not met the required residency requirements. <i>Active: 02/01/06. Previously under ARC 30. Modified: 09/30/07</i>	None	
181	Procedure code was invalid on the date of service. <i>Active: 02/01/06 Modified: 09/30/07</i>	None	
182	Procedure modifier was invalid on the date of service. <i>Active: 02/01/06. Modified: 8/8/05, 09/30/07</i>	None	
183	The referring provider is not eligible to refer the service billed. <i>Active: 6/30/05</i>	None	
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. <i>Active: 6/30/05</i>	None	
185	The rendering provider is not eligible to perform the service billed. <i>Active: 6/30/05</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
186	Level of care change adjustment. <i>Active: 02/01/06 Modified: 09/30/07</i>	None	
187	Health Savings account payments. <i>Active: 6/30/05</i>	None	
188	This product/procedure is only covered when used according to FDA recommendations. <i>Active: 6/30/05</i>	None	
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service. <i>Active: 6/30/05</i>	None	
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. <i>Active: 10/31/05</i>	None	
191	Not a work related injury/illness and thus not the liability of the worker's compensation carrier. <i>Active: 10/31/05 Modified: 09/30/07</i>	None	
192	Non-standard adjustment code from paper remittance. NOTE: this code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason code, specifically Deductible, Coinsurance and Co-payment. <i>Active: 10/31/05 Modified: 09/30/07</i>	None	
193	Original payment decision is being maintained. This claim was processed properly the first time. <i>Active: 2/28/06</i>	None	
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. <i>Active: 02/28/06 Modified: 09/30/07</i>	None	
195	Refund issued to an erroneous priority payer for this claim/service. <i>Active: 02/28/06 Modified: 09/30/07</i>	None	
196	Claim/service denied based on prior payer's coverage determination. <i>Active: 6/30/06 Deactivated: 2/1/07 Use code 136</i>	None	
197	Precertification/authorization/notification absent. <i>Active: 10/31/06 Previously under ARC 62. Modified: 09/30/07</i>	None	
		D93	Predetermination of benefits is required for services performed by a non participating provider.
		E9	Benefits have been reduced due to non-compliance with cost containment provision of the contract.
		P7	Reduction due to non-compliance with referral or pre-certification requirements.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		P9	Reduction due to non-compliance with referral or pre-certification requirements.
		01	Benefit reduced because of non-compliance with cost containment provision of contract.
		01D	Benefits are payable only when treatment has been pre-determined.
		20	This service is not covered. No prior authorization on record.
		21	This service requires a referral or an authorization.
		134	No record of pre-authorization from ODS Behavioral on file.
198	Precertification/authorization exceeded	None	
	<i>Active: 10/31/06 Previously under ARC 62. Modified: 09/30/07</i>	95	Level of service billed does not match level of service authorized.
199	Revenue code and Procedure code do not match.	None	
	<i>Active: 10/31/06</i>		
200	Expenses incurred during lapse in coverage.	None	
	<i>Active: 10/31/06</i>		
201	Workers Compensation case settle. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement.	None	
	<i>Active: 10/31/06</i>		
202	Non-covered personal comfort or convenience services.	None	
	<i>Active: 2/28/07 Modified: 9/30/07</i>	N1	Personal comfort items are not covered.
203	Discontinued or reduced service.	None	
	<i>Active: 2/28/07 Modified: 9/30/07</i>		
204	The service/equipment/drug is not covered under the patient's current benefit plan.	None	
	<i>Active: 2/28/07</i>	B0	This vision service is not covered.
		D15	No payment is provided for the following fees. Periodontal charting, office calls, consultations or
		D26	Payment is not provided for removal of overhangs, re-contouring, discing, polishing teeth and/or restorations.
		D30	Implants, implant related services and copings are not covered.
		D34	No payment is provided for gnathologic recordings or like procedures.
		D48	Payment is not provided for occlusal guards or like appliances.
		D49	Payment is not provided for procedures or appliances for splinting of teeth.
		D57	Payment is not provided for relative analgesia, pre-medications, sedations, and hypnosis for any purpose.
		D58	Payment is not provided for oral medications or prescriptions.
		D61	Payment is not provided for preventive control programs, including plaque control, sealants, etc.
		D62	Payment is not provided for orthodontic services, including diagnosis and tooth guidance appliances.
		D63	Payment is not provided for repair or replacement of orthodontic appliances.

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
		D65	Payment is not provided for hospitalization, including hospital visits and procedures.
		D73	Not a covered benefit.
		E0	This service is not covered.
		J0	This service is not covered.
		P0	This service is not covered.
		R0	This service is not covered.
		W0	This service is not covered.
		Y0	This service is not covered.
		Y6	This service is not covered.
		02	Classes and other educational/instructional services or materials are not covered.
		06	Non durable medical equipment is not covered.
		09	This service/expense is not covered.
		11	Non-covered drug/supply.
		12	There is no benefit for mailing or handling fees.
		24	No coverage for cosmetic services or supplies.
		25	No coverage for telephone consultation.
		26	Charges for missed appointments are not covered.
		27	Routine immunization not covered.
		29	Medications not requiring a doctor's prescription are excluded by the plan.
		32	This preventive health care service is not covered.
		33	In the future, please submit a complete itemization of services, including medical diagnosis, description and charge for each service.
		38	Charges for reports and/or finance charges are not covered.
		59	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.
		11D	Specialized and experimental techniques or precision attachments are not covered.
		125	State and/or local taxes are not covered.
		19D	Accident related procedures are not covered under this dental plan.
		715	No payment is provided for the following fees: periodontal charting, office calls, consultations or broken appointments.
205	Pharmacy discount card processing fee. <i>Active: 7/9/07</i>	None	
206	National Provider Identifier - missing. <i>Active: 7/9/07 Modified: 9/30/07</i>	None	
207	National Provider Identifier - Invalid format. <i>Active: 7/9/07 Modified: 9/30/07 Deactivate: 05/23/08</i>	None	
208	National Provider Identifier - Not matched. <i>Active: 7/9/07 Modified: 9/30/07</i>	None	
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. <i>Active: 7/9/007</i>	None	
210	Payment adjusted because pre-certification/authorization not received in a timely	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
	Active: 7/9/07		
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	None	
	Active: 7/9/07		
212	Administrative surcharges are not covered.	None	
	Active: 11/05/07		
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	None	
	Active: 1/27/08		
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	None	
	Active: 1/27/08		
215	Based on subrogation of a third party settlement	None	
	Active: 1/27/08		
216	Based on the findings of a review organization.	None	
	Active: 1/27/08		
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	None	
	Active: 1/27/08		
218	Based on entitlement to benefits. (Note: To be used for Workers' Compensation only)	None	
	Active: 1/27/08		
219	Based on extent of injury. (Note: To be used for Workers' Compensation only)	None	
	Active: 1/27/08		
220	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.	None	
	Active: 1/27/08		
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	None	
	Active: 1/27/08		
A0	Patient refund amount.	None	
	Active: 1/1/95		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	None	
	<i>Active: 1/1/95 Last Modified: 10/31/06 Eff 6/1/07 At least one Remark Code must be provided.</i>	BZ	The charge exceeds the amount allowed.
		D66	Payment is provided for dental treatment performed in the hospital at the same fees as those covered in the dental office.
		D80	Claim processed in accordance with schedule of allowance provided in contract.
		EX	The charge exceeds the amount allowed.
		E2	The charge exceeds the amount allowed.
		JX	The charge exceeds the amount allowed.
		JZ	The charge is over the maximum plan allowance for this procedure.
		J1	The charge is over the maximum plan allowance for this procedure.
		J2	The charge exceeds the amount allowed.
		J3	The charge is over the maximum plan allowance for this procedure.
		PX	The charge exceeds the amount allowed.
		PZ	The charge exceeds the amount allowed.
		P1	The charge exceeds the amount allowed.
		P2	The charge exceeds the amount allowed.
		P3	The plan limits benefits for this service.
		R1	The fee charges exceeds the maximum allowance.
		R2	Claim processed in accordance with schedule of allowance.
		R3	Charges greater than rate allowed.
		R7	The charge exceeds the amount allowed.
		Y1	Processed in accordance with schedule of allowance provided in contract.
		Y2	Processed in accordance with schedule of allowance provided in contract.
		Y3	Charges greater than rate allowed.
		Y7	The charge exceeds the amount allowed.
		Y8	The charge exceeds the amount allowed.
		54	Coverage based on Medicare allowed amount.
		83	The maximum benefit allowable under this plan is the normal benefit less the amount payable under your primary plan.
A2	Contractual adjustment.	None	
	<i>Active: 1/1/95 Last Modified: 2/28/07 Deactivated on 1/1/08</i>		
A4	Medicare Claim PPS Capital Day Outlier Amount.	None	
	<i>Active: 1/1/95</i>		
A5	Medicare Claim PPS Capital Cost Outlier Amount.	None	
	<i>Active: 1/1/95</i>		
A6	Prior hospitalization or 30 day transfer requirement not met.	None	
	<i>Active: 1/1/95</i>		
A7	Presumptive Payment Adjustment.	None	
	<i>Active: 1/1/95</i>		
A8	Claim denied; ungroupable DRG.	None	
	<i>Active: 1/1/95</i>		

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
B1	Non-covered visits. <i>Active: 1/1/95</i>	None	
B4	Late filing penalty. <i>Active: 1/1/95</i>	None	
B5	Coverage/program guidelines were not met or were exceeded. <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	9B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. <i>Active: 1/1/95 Last Modified: 10/31/98</i>	9B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Alternative services were available, and should have been utilized. <i>Active: 1/1/95 Modified: 9/30/07</i>	None	
B9	Patient is enrolled in a Hospice. <i>Active: 1/1/95 Modified: 9/30/07</i>	9B9	Services not covered because the patient is enrolled in Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test. <i>Active: 1/1/95</i>	None	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. <i>Active: 1/1/95</i>	None	
B12	Services not documented in patient's medical records. <i>Active: 1/1/95</i>	9B1	Services not documented in patient's medical records.
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. <i>Active: 1/1/95 Modified: 10/31/06, 9/30/07</i>	None	
B16	New Patient' qualifications were not met. <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	TGK	Our records show patient has been treated by this provider/clinic within the past 3 years. Criteria for new patient code has not been met.
B18	This procedure code/modifier was invalid on the date of service or claim submission. <i>Active: 1/1/95 Modified: 9/30/07</i>	None	
B20	Procedure/service was partially or fully furnished by another provider. <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i>	None	

HIPAA ARC Code	Health Care Claim Adjustment Reason Code Description	EX Code	Explanation Code Description
B22	This payment is adjusted based on the diagnosis. <i>Active: 1/1/95 Last Modified: 2/28/01</i>	None	
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. <i>Active: 1/1/95 Modified: 2/28/01</i>	None	
D16	Claim lacks prior payment information. <i>Active: 1/1/95 Deactivated: 6/30/07</i>	None	
D17	Claim/Service has invalid non-covered days. <i>Active: 1/1/95 Deactivated: 6/30/07</i>	None	
D18	Claim/Service has missing diagnosis information. <i>Active: 1/1/95 Deactivated: 6/30/07</i>	None	
D19	Claim/Service lacks Physician/Operative or other supporting documentation. <i>Active: 1/1/95 Deactivated: 6/30/07</i>	None	
D20	Claim/Service missing service/product information. <i>Active: 1/1/95 Deactivated: 6/30/07</i>	None	
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) -- Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code <i>Active: 1/27/08 To Be Deactivated: 1/1/09</i>	None	
W1	Worker's Compensation State Fee Schedule Adjustment.	None	