

| 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 | |
| | | 515 | The procedure code and/or bill type is inconsistent with the place of service. |
| | 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 | | |

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| 14 | The date of birth follows the date of service. <i>Active: 1/1/95</i> | None >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 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 | |
| | | 33 | Please submit a complete itemization of services, including medical diagnosis, description and charge for each service. |
| | <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. |
| | | 48C | Information requested from the provider has not been received. Benefit has been made for the assessment fee. |
| | | 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 been received. |
| | | 58 | Please submit medical records for utilization review of pending days. |
| | | 60M | Provider is requested to submit claim for pricing to: Cofinity, PO Box 2720, Farmington Hills, MI 48333. |
| | | 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. |
| | | 110 | A signed, valid consent form required. Please submit with claim. |
| | | 113 | For further consideration, the provider needs to submit chart notes for this date of service. |
| | | 670 | Lab pathology report is required. |
| | | 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) <i>Active: 1/1/95 Modified: 6/30/06, 9/30/07 Effective 4/1/07 a Remark Code must be provided.</i> | None | |
| | | 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. |
| | | 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. |

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| | | 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. |
| | | 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 | |
| | Active: 1/1/95 | 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 | |
| | Active: 1/1/95 Modified: 9/30/07 | 67 | Work related claims are not covered. |
| 20 | This injury/illness is covered by the liability carrier. | None | |
| | Active: 1/1/95 Modified: 9/30/07 | 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 | |
| | Active: 1/1/95 Modified: 09/30/07 | | |
| 22 | This care may be covered by another payer per coordination of benefits. | None | |
| | Active: 1/1/95. Modified: 2/28/01, 09/30/07 | >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 | |
| | Active: 1/1/95. Modified: 6/30/05, 09/30/07 | 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. |

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| | | 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. <i>Active: 1/1/95. Modified: 6/30/00, 09/30/07</i> | None | |
| | | I1 | Capitation applied. |
| 25 | <i>Payment denied. The stoploss deductible has not been met. Active: 1/1/95 Deactivate: 4/1/08</i> | None | |
| 26 | Expenses incurred prior to coverage. <i>Active: 1/1/95</i> | None | |
| | | >I | The date of service is prior to the member's effective date. |
| | | >6 | The date of service is before dependent effective date. |
| | | >9 | The date of service is before signature date. |
| | | S? | The date of service is prior to the effective date of coverage. |
| | | SR | The date of service is prior to the patient's effective date. |
| | | S1 | Plan was not effective on this date of service. |
| 27 | Expenses incurred after coverage terminated. <i>Active: 1/1/95</i> | None | |
| | | >L | Lapse in coverage. |
| | | >O | Benefit status shows no longer eligible. |
| | | >2 | Group no longer eligible. |
| | | >3 | Division no longer eligible. |
| | | >4 | Member no longer eligible. Please check ID card. |
| | | >7 | Spouse no longer eligible. |
| | | SM | Coverage is no longer in force. |
| | | SO | Member no longer eligible. Please check ID card. |
| | | SQ | The patient is no longer eligible. |
| 29 | The time limit for filing has expired. <i>Active: 1/1/95</i> | None | |
| | | S5 | Timely-filing not met. Claim submitted after contract time limit. |
| 30 | <i>Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. Active: 1/1/95 Deactivated: 2/1/06. Replaced by 177, 178, 179 & 180</i> | | |
| 31 | Patient cannot be identified as our insured. <i>Active: 1/1/95 Modified: 09/30/07</i> | None | |
| | | >? | Eligibility not known. |
| | | ># | Group, division ID on CF member record unknown. |
| | | >B | Member and spouse only coverage. |
| | | >D | Member and child only coverage. |
| | | >E | Spouse and child only coverage. |
| | | >F | Spouse only coverage. |
| | | >G | Child only coverage. |
| | | >P | Eligibility information has not been received. |
| | | >V | Evidence of insurability failed. |
| | | D72 | OEA's records reflect this patient is not covered. Please contact your school district. |
| | | MNF | Patient not found. Please check ID card. |
| | | SB | Member and spouse only coverage. |
| | | SD | Member and children only coverage. |
| | | SL | Retirees are not covered. |
| | | SN | Patient is not eligible for benefits. |
| | | SP | Eligibility information has not been received. |
| | | ST | The patient is not eligible. |
| | | S7 | Member is over maximum age. |

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| | | 22 | 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. <i>Active: 1/1/95</i> | None | |
| | | >A | Overage dependent. |
| | | >S | Dependent student is no longer eligible. |
| | | >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. |

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| | | 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. |
| | | 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. |
| | | 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. |

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| | | 502 | This procedure code is not valid for Medicare. Please resubmit with a valid code for reconsideration of benefits. |
| | | 504 | This service cannot be paid to this provider type. Not HPSA provider or procedure is 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. |
| | | 507 | Priced with covered G0101. For reconsideration, please send corrected claims using original Medicare's coding guidelines. |
| | | 513 | Service/item noncovered by CMS and ODS Medicare Advantage. ODS requires documentation of prior member notification before billing member. |
| | | 514 | Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service. |
| | | 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 creditable 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 | |

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| 54 | Multiple physicians/assistants are not covered in this case. | None | |
| | <i>Active: 1/1/95</i> | 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. | None | |
| | <i>Active: 1/1/95 Modified: 09/30/07</i> | 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. | None | |
| | <i>Active: 1/1/95 Modified: 09/30/07</i> | | |
| 57 | <i>Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.</i> | None | |
| | <i>Active: 1/1/95 Deactivated: 6/30/07 Split into codes 150, 151, 152, 153 and 154</i> | | |
| 58 | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. | None | |
| | <i>Active: 1/1/95 Modified: 2/28/01, 09/30/07</i> | | |
| 59 | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia) | None | |
| | <i>Active: 1/1/95 Modified: 2/28/07, 09/30/07</i> | | |
| 60 | Charges for outpatient services with this proximity to inpatient services are not covered. | None | |
| | <i>Active: 1/1/95</i> | | |
| 61 | This change is to be effective 4/1/2008: penalty for failure to obtain second surgical opinion. | None | |
| | <i>Active 1/1/95. Modified: 6/30/00, 09/30/07</i> | | |
| 62 | <i>Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.</i> | None | |
| | <i>Active: 1/1/95 Last Modified: 10/31/06 Deactivated: 4/1/07</i> | | |
| 66 | Blood deductible. | None | |
| | <i>Active: 1/1/95</i> | | |
| 69 | Day outlier amount. | None | |
| | <i>Active: 1/1/95</i> | | |
| 70 | Cost outlier - Adjustment to compensate for additional costs. | None | |
| | <i>Active: 1/1/95 Last Modified: 6/30/01</i> | 301 | This is your outlier payment. |
| 74 | Indirect Medical Education Adjustment. | None | |
| | <i>Active: 1/1/95</i> | | |
| 75 | Direct Medical Education Adjustment. | None | |
| | <i>Active: 1/1/95</i> | 975 | Direct medical education adjustment. |
| 76 | Disproportionate Share Adjustment. | None | |
| | <i>Active: 1/1/95</i> | | |
| 78 | Non-covered days/room charge adjustment. | None | |
| | <i>Active: 1/1/95</i> | 124 | Plan allows up to semi-private room rate. |

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| 85 | Interest amount. <i>Active: 1/1/95</i> | None | |
| 87 | Transfer amount. <i>Active: 1/1/95</i> | 987 | Transfer amount. |
| 88 | Adjustment amount represents collection against receivable created in prior overpayment. <i>Active: 1/1/95 To be Deactivated: 6/30/07</i> | None | |
| 89 | Professional fees removed from charges. <i>Active: 1/1/95</i> | 989 | Professional fees removed from charges. |
| 90 | Ingredient cost adjustment. <i>Active: 1/1/95</i> | None | |
| 91 | Dispensing fee adjustment. <i>Active: 1/1/95</i> | None | |
| 94 | Processed in Excess of charges. <i>Active: 1/1/95</i> | None 006 | This is the case rate/DRG payment. |
| 95 | Plan procedures not followed. <i>Active: 1/1/95 Modified: 6/30/00, 09/30/07</i> | None AO DO 505 | Adjudication override. Duplicate override. 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. |

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| | | 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. |
| | | D82 | Appliances, restorations or procedures are not payable when done to increase vertical dimension. |
| | | 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. |
| | | 73 | Only charges for initial diagnostic services are covered. The plan excludes expense for treatment of this condition. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|--|
| | | 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. |
| | | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| | | 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. |
| | | 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. |
| | | TGP | Service is considered a mutually exclusive procedure to another code billed. If required, modifier may not be present/correctly used. |
| | | 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. |
| | | 470 | Retreatment of root canal or apical surgery performed within 12 months of initial treatment is considered part of the initial treatment fee. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| | | 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. |
| | | 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. |
| | | 450 | Not covered under the dental plan. Service may be eligible for reimbursement under the members Health Reimbursement Account. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|--|
| | | 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.</i> <i>Replaced by 157, 158 or 159.</i> | None | |
| 114 | Procedure/product not approved by the Food and Drug Administration. <i>Active: 1/1/95</i> | None | |
| 115 | Procedure postponed, canceled or delayed. <i>Active: 1/1/95</i> <i>Modified: 2/28/01, 09/30/07</i> | None | |
| 116 | The advance indemnification notice signed by the patient did not comply with requirements. <i>Active: 1/1/95</i> <i>Modified: 2/28/01, 09/30/07</i> | None | |
| 117 | Transportation is only covered to the closest facility that can provide the necessary care. <i>Active: 1/1/95</i> <i>Modified: 2/28/01, 09/30/07</i> | None | |
| 118 | ESRD network support adjustment. <i>Active: 1/1/95 Modified: 09/30/07</i> | None | |
| 119 | Benefit maximum for this time period has been reached. <i>Active: 1/1/95 Last Modified: 2/29/04</i> | None | |
| | | 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 panographic) 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|---|
| | | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|---|
| | | 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. <i>Active: 1/1/95 Deactivate: 6/30/07 Use code 24</i> | None | |
| 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. |
| | | 510 | Denied for criteria not met; required related code (drug/supply/procedure code) must be billed on same claim. |
| | | 511 | Reduced, downcoded, or denied because payment already made for same/similar procedure within set time frame. |
| 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. | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|-------------|---|
| | <i>Active: 2/28/97 Modified: 2/28/01, 09/30/07</i> | | |
| 130 | Claim submission fee. | None | |
| | <i>Active: 2/28/97 Last Modified: 6/30/01</i> | D03 | A separate fee for completion of a claim form is not covered. |
| 131 | Claim specific negotiated discount. | None | |
| | <i>Active: 2/28/97</i> | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|---|
| | | 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. |
| | | 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 |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| | | 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.. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| | | 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). |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| | | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|---|
| | | 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. |
| | | T5J | Paid according to your PPO contract with NPPN/Belin Health & Thedacare. |
| | | T5K | Paid according to your PPO contract with IHP/Medlink. |
| | | T5L | Paid according to your PPO contract with IHP/PSI/UHN. |
| | | T5M | Paid according to your PPO contract with IHP/FEDMED. |
| | | T5N | Paid according to your PPO contract with Provider Select (PSI). |
| | | T5O | Paid according to your PPO contract with PMCS Networks. |
| | | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|--|
| | | 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. |
| | | 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. | None | |
| | | D70 | Payment is not provided for incomplete treatment. Please file on the completion date. |
| | <i>Active: 10/31/98 Modified: 09/30/07</i> | 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 | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|--|
| 137 | Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. <i>Active: 2/28/99 Modified: 09/30/07</i> | None | |
| 138 | Appeal procedures not followed or time limits not met. <i>Active: 6/30/99 Modified: 09/30/07</i> | H38 | 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 | |
| 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|------------------------------|
| 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 | |
| 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 | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---|---|
| 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 62 98 705 | Payment is provided only for charges by a licensed dentist. This type of provider is not covered. The provider is not covered or working in a state approved program. This service is not covered when performed by this type of provider. 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. | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|---|
| | Active: 02/01/06. Previously under ARC B17. Modified: 09/30/07 | | |
| 176 | Prescription is not current. Active: 02/01/06. Previously under ARC B17. Modified: 09/30/07 | None | |
| 177 | Patient has not met the required eligibility requirements. Active: 02/01/06. Previously under ARC 30 Modified: 09/30/07 | None | |
| 178 | Patient has not met the required spend down requirements. Active: 02/01/06. Previously under ARC 30 Modified: 09/30/07 | None | |
| 179 | Patient has not met the required waiting requirements. Active: 02/01/06. Previously under ARC 30. Modified: 09/30/07 | >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. Active: 02/01/06. Previously under ARC 30. Modified: 09/30/07 | None | |
| 181 | Procedure code was invalid on the date of service. Active: 02/01/06 Modified: 09/30/07 | None | |
| 182 | Procedure modifier was invalid on the date of service. Active: 02/01/06. Modified: 8/8/05, 09/30/07 | None | |
| 183 | The referring provider is not eligible to refer the service billed. Active: 6/30/05 | None | |
| 184 | The prescribing/ordering provider is not eligible to prescribe/order the service billed. Active: 6/30/05 | None | |
| 185 | The rendering provider is not eligible to perform the service billed. Active: 6/30/05 | None | |
| 186 | Level of care change adjustment. Active: 02/01/06 Modified: 09/30/07 | None | |
| 187 | Health Savings account payments. Active: 6/30/05 | None | |
| 188 | This product/procedure is only covered when used according to FDA recommendations. Active: 6/30/05 | None | |
| 189 | "Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service. Active: 6/30/05 | None | |
| 190 | Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. Active: 10/31/05 | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|---|
| 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 | <i>Claim/service denied based on prior payer's coverage determination.</i> <i>Active: 6/30/06 Deactivated: 2/1/07 Use code 136</i> | None | |
| 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. |
| | | 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 <i>Active: 10/31/06 Previously under ARC 62. Modified: 09/30/07</i> | None | |
| | | 95 | Level of service billed does not match level of service authorized. |
| 199 | Revenue code and Procedure code do not match. <i>Active: 10/31/06</i> | None | |
| 200 | Expenses incurred during lapse in coverage. | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|---------|--|
| | Active: 10/31/06 | | |
| 201 | Workers Compensation case settle. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. | None | |
| | Active: 10/31/06 | | |
| 202 | Non-covered personal comfort or convenience services. | None | |
| | Active: 2/28/07 Modified: 9/30/07 | N1 | Personal comfort items are not covered. |
| 203 | Discontinued or reduced service. | None | |
| | Active: 2/28/07 Modified: 9/30/07 | | |
| 204 | The service/equipment/drug is not covered under the patient's current benefit plan. | None | |
| | Active: 2/28/07 | 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. |
| | | 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. |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|---|
| | | 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. |
| | | 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 <i>Active: 7/9/07</i> | None | |
| 211 | National Drug Codes (NDC) not eligible for rebate, are not covered. <i>Active: 7/9/07</i> | None | |
| 212 | Administrative surcharges are not covered. <i>Active: 11/05/07</i> | None | |
| 213 | Non-compliance with the physician self referral prohibition legislation or payer policy. <i>Active: 1/27/08</i> | None | |
| 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) <i>Active: 1/27/08</i> | None | |
| 215 | Based on subrogation of a third party settlement <i>Active: 1/27/08</i> | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|------------------------------|
| 216 | Based on the findings of a review organization. <i>Active: 1/27/08</i> | None | |
| 217 | Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only) <i>Active: 1/27/08</i> | None | |
| 218 | Based on entitlement to benefits. (Note: To be used for Workers' Compensation only) <i>Active: 1/27/08</i> | None | |
| 219 | Based on extent of injury. (Note: To be used for Workers' Compensation only) <i>Active: 1/27/08</i> | None | |
| 220 | The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only) <i>Active: 1/27/08</i> | None | |
| 221 | Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution) <i>Active: 1/27/08</i> | None | |
| 222 | Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. <i>Active: 6/1/08</i> | | |
| 223 | Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. <i>Active: 6/1/08</i> | | |
| 224 | Patient identification compromised by identity theft. Identify verification required for processing this and future claims. <i>Active: 6/1/08</i> | | |
| 225 | Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) <i>Active: 6/1/08</i> | | |
| A0 | Patient refund amount. <i>Active: 1/1/95</i> | None | |
| 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 | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|-------------|--|
| | <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. |
| | | 83 | The maximum benefit allowable under this plan is the normal benefit less the amount payable under your primary plan. |
| A2 | <i>Contractual adjustment.</i> | 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> | | |
| B1 | Non-covered visits. | None | |
| | <i>Active: 1/1/95</i> | | |
| B4 | Late filing penalty. | None | |
| | <i>Active: 1/1/95</i> | | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|--|---------|--|
| 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. | None | |
| | <i>Active: 1/1/95 Modified: 9/30/07</i> | | |
| 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. | 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. | | |
| | <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. | None | |
| | <i>Active: 1/1/95</i> | | |
| B14 | Only one visit or consultation per physician per day is covered. | None | |
| | <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i> | | |
| B15 | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. | None | |
| | <i>Active: 1/1/95 Modified: 10/31/06, 9/30/07</i> | | |
| B16 | New Patient' qualifications were not met. | None | |
| | <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. | None | |
| | <i>Active: 1/1/95 Modified: 9/30/07</i> | | |
| B20 | Procedure/service was partially or fully furnished by another provider. | None | |
| | <i>Active: 1/1/95 Modified: 2/28/01, 9/30/07</i> | | |
| B22 | This payment is adjusted based on the diagnosis. | None | |
| | <i>Active: 1/1/95 Last Modified: 2/28/01</i> | | |
| B23 | Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. | None | |

| HIPAA ARC Code | Health Care Claim Adjustment Reason Code Description | EX Code | Explanation Code Description |
|----------------|---|-------------|------------------------------|
| | <i>Active: 1/1/95 Modified: 2/28/01</i> | | |
| 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 | |