Alameda Alliance for Health Standardized Reason Code Crosswalk

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
826	DIAGNOSIS CODE #1 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1798	THERE IS MORE THAN ONE OCCURRENCE OF PROC ON SAME DOB WITH SURGICAL ASSISTANT MODIFIER ONLY ONE SURGICAL ASSISTANT IS ALLOWED PER PROCEDURE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M250	
3	CLAIM MUST BE RESUBMITTED WITH A MEDICARE EOB OR REMITTANCE ADVICE	163	Attachment/other documentation referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 06/02/2013	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 07/01/2008
254	PROCEDURE CODE IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
528	DIAGNOSIS CODE NOT ON CLAIM	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
529	AMOUNT BILLED IS REQUIRED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M54	Missing/incomplete/invalid total charges. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
530	CLAIM SERVICE DATES ARE REQUIRED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
557	MEMBER IS NOT ELIGIBLE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N30	Patient ineligible for this service. Start: 01/01/2000 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)
592	NO BENEFITS FOUND FOR DATES OF SERVICE	B1	Non-covered visits. Start: 01/01/1995	N30	Patient ineligible for this service. Start: 01/01/2000 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
609	INVALID PLACE OF SERVICE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M77	Missing/incomplete/invalid/inappropriate place of service. Start: 01/01/1997 | Last Modified: 03/14/2014 Notes: (Modified 2/28/03, 3/1/2014, 3/14/2014)
617	CLAIM HAS NO LINEITEMS	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M54	Missing/incomplete/invalid total charges. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
630	AUTHORIZATION IS DENIED	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC). Start: 03/01/2015
631	REFERRAL ID IS REQUIRED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N276	Missing/incomplete/invalid other payer referring provider identifier. Start: 12/02/2004
632	REFERRAL NOT FOUND	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Start: 09/30/2012 | Last Modified: 06/02/2013	N489	Missing referral form. Start: 07/01/2008

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
641	AUTHORIZATION IS REQUIRED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
809	SERVICE NOT AUTHORIZED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N596	Records reflect the injured party did not complete a Medical Authorization for this loss. Start: 07/15/2013
827	DIAGNOSIS CODE #2 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
828	DIAGNOSIS CODE #3 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
829	DIAGNOSIS CODE #4 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
864	CLAIM DATES NOT WITHIN AUTHORIZATION DATES	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
866	REFERRAL INSURED DOES NOT MATCH CLAIM INSURED	31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. Start: 10/12/2001
867	REFERRAL PROVIDER DOES NOT MATCH CLAIM PROVIDER	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records. Start: 07/15/2013
868	SERVICE NOT REFERRED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N630	Referral not authorized by attending physician. Start: 07/15/2013
942	THIS IS A CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	N59	Alert: Please refer to your provider manual for additional program and provider information. Start: 01/01/2000 | Last Modified: 11/01/2015 Notes: (Modified 4/1/07, 11/1/09, 11/1/2015)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
943	THIS IS A PARTIALLY CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
1017	AUTHORIZATION IS CLOSED	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1027	PROCEDURE NOT INDICATED FOR A MALE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	MA39	Missing/incomplete/invalid gender. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1028	PROCEDURE NOT INDICATED FOR A FEMALE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	MA39	Missing/incomplete/invalid gender. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1029	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M383	Not covered when deemed cosmetic.

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1030	PROCEDURE IS AN UNLISTED PROCEDURE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301
1032	PROCEDURE INDICATED FOR PEDIATRC PATIENT (<= 17 YEARS OLD)	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
1033	PROCEDURE INDICATED FOR MATERNITY PATIENT (12-55 YEARS OLD)	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
1034	PROCEDURE INDICATED FOR ADULT PATIENT (OVER 14 YEARS OLD)	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
1035	PROCEDURE IS CLASSIFIED AS AN EXPERIMENTAL PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1036	E344 - VALUE DOES NOT MATCH CLAIM LEVEL DIAGNOSIS	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M49	Missing/incomplete/invalid value code(s) or amount(s). Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1037	PROCEDURE SUBMITTED WITH MODIFIER 26, BUT PROFESSIONAL RVU = 0	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013
1038	PROCEDURE REPLACED DUE TO AGE	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
1039	ASSISTANT SURGEON DENIED FOR THIS PROCEDURE	194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Start: 01/01/1997 | Last Modified: 10/31/2002 Notes: (Modified 10/31/02)
1040	PROCEDURE REPLACED WITH ESTABLISHED PATIENT PROCEDURE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N431	Not covered with this procedure. Start: 11/05/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1041	PROCEDURE IS AN INCIDENTAL PROCEDURE, PRIMARY PROCEDURE PRESENT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N19	Procedure code incidental to primary procedure. Start: 01/01/2000
1042	PROCEDURE IS MUTUALLY EXCLUSIVE TO ANOTHER PROCEDURE ON CLAIM	231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 07/01/2009 | Last Modified: 09/20/2009	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed. Start: 07/15/2013
1043	PROCEDURE IS POST OPERATIVE	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. Start: 01/01/1995	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 01/01/1997
1044	PROCEDURE IS PRE OPERATIVE	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. Start: 01/01/1995	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 01/01/1997
1045	PROCEDURE REPLACED DUE TO REBUNDLING	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1046	PROCEDURE REPLACED DUE TO SEX	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1047	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N188	The approved level of care does not match the procedure code submitted. Start: 02/28/2003
1048	PROCEDURE IS A MEDICAL VISIT, PRIMARY PROCEDURE PRESENT	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N431	Not covered with this procedure. Start: 11/05/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)
1049	PROCEDURE NOT EXPECTED WITH DIAGNOSIS CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1050	PROCEDURE INCLUDES UNILATERAL OR BILATERAL PERFORMANCE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/	N644	Reimbursement has been made according to the bilateral procedure rule. Start: 07/15/2013

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1051	PROCEDURE IS A BILATERAL CODE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N644	Reimbursement has been made according to the bilateral procedure rule. Start: 07/15/2013
1052	PROCEDURE ALREADY PERFORMED ALLOWABLE NUMBER OF TIMES IN A PATIENTS LIFETIME	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met. Start: 11/18/2005
1053	PROCEDURE ALREADY PERFORMED ALLOWABLE NUMBER OF TIMES IN A DAY	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met. Start: 11/18/2005
1054	PROCEDURE INDICATES POSSIBLE WORKERS COMPENSATION/AUTO LIABILITY	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	N418	Misrouted claim. See the payer's claim submission instructions. Start: 08/01/2007
1055	PROCEDURE INDICATES POSSIBLE DENTAL LIABILITY	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1056	DIAGNOSIS INDICATES POSSIBLE WORKERS COMPENSATION/AUTO LIABILITY	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	N418	Misrouted claim. See the payer's claim submission instructions. Start: 08/01/2007
1057	DIAGNOSIS INDICATES POSSIBLE DENTAL LIABILITY	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1058	DIAGNOSIS 1 INDICATES POSSIBLE WORKERS COMPENSATION/AUTO CLAIM	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	N418	Misrouted claim. See the payer's claim submission instructions. Start: 08/01/2007
1082	DIAGNOSIS CANNOT BE USED AS PRINCIPAL FOR DRG PROCESSING	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1083	INVALID ADMISSION AGE FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1084	INVALID PATIENT SEX FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1085	INVALID DISCHARGE STATUS FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1086	ILLOGICAL PRINCIPLE DIAGNOSIS FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1087	INVALID PRINCIPLE DIAGNOSIS FOR DRG PROCESSING	167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 06/30/2005 | Last Modified: 09/20/2009	N30	Patient ineligible for this service. Start: 01/01/2000 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)
1088	INVALID BIRTHWEIGHT IN GRAMS FOR DRG PROCESSING	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N207	Missing/incomplete/invalid weight. Start: 06/30/2003 | Last Modified: 11/18/2005 Notes: (Modified 11/18/05)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1089	CONFLICTING BIRTHWEIGHT / DIAGNOSIS FOR DRG PROCESSING	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N207	Missing/incomplete/invalid weight. Start: 06/30/2003 | Last Modified: 11/18/2005 Notes: (Modified 11/18/05)
1090	NON-SPECIFIC BIRTHWEIGHT / DIAGNOSIS FOR DRG PROCESSING	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N207	Missing/incomplete/invalid weight. Start: 06/30/2003 | Last Modified: 11/18/2005 Notes: (Modified 11/18/05)
1091	INVALID DISCHARGE AGE FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1092	INVALID LENGTH OF STAY FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1093	INVALID FACILITY OR COUNTY FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1094	INVALID ADMISSION SOURCE FOR DRG PROCESSING	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
1216	DIAGNOSIS CODE #5 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1217	DIAGNOSIS CODE #6 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1218	DIAGNOSIS CODE #7 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1219	DIAGNOSIS CODE #8 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1220	DIAGNOSIS CODE #9 IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1221	ADMIT DIAGNOSIS CODE IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M65	Missing/incomplete/invalid admitting diagnosis.
1348	PROCEDURE CODE IS NOT VALID FOR DATE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301
1352	DIAGNOSIS CODE #1 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1353	DIAGNOSIS CODE #2 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1354	DIAGNOSIS CODE #3 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1355	DIAGNOSIS CODE #4 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1356	DIAGNOSIS CODE #5 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1357	DIAGNOSIS CODE #6 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1358	DIAGNOSIS CODE #7 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1359	DIAGNOSIS CODE #8 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1360	DIAGNOSIS CODE #9 IS NOT VALID FOR DATE	146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1385	DUPLICATE CLAIM	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N522	Duplicate of a claim processed, or to be processed, as a crossover claim. Start: 11/01/2009 | Last Modified: 03/01/2010
1387	MULTI DUP CLMS FOR SRV LINE	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated. Start: 02/28/2002
1398	STATUS CAN NOT BE CHANGED, AN ADJ/VD/REV HAS BEEN ISSUED ON ORIG CLM	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1399	PROVIDER RETURN NOT SUFFICIENT TO COVER SELECTED CLAIMS(S)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely. Start: 10/31/2001 | Stop: 07/01/2016 | Last Modified: 11/01/2013
1502	PROVIDER UNDER INVESTIGATION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N665	Services by an unlicensed provider are not reimbursable. Start: 07/15/2013
1503	PROVIDER UNDER REVIEW BY FRAUD/ABUSE UNIT	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N665	Services by an unlicensed provider are not reimbursable. Start: 07/15/2013
1504	PROVIDER DEBARRED FROM THE PLAN	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N665	Services by an unlicensed provider are not reimbursable. Start: 07/15/2013
1517	CLAIM RECEIVED AFTER FILING LIMIT CUTOFF DATE	29	The time limit for filing has expired. Start: 01/01/1995	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1673	PROCEDURE CODE REQUIRES A MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1675	MODIFIER IS INVALID	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1676	PROCEDURE DOES NOT SUPPORT TECHNICAL COMPONENT MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1677	PROCEDURE DOES NOT SUPPORT PROFESSIONAL COMP MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1678	PROCEDURE DOES NOT SUPPORT MULTIPLE PROCEDURE MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1679	PROCEDURE DOES NOT SUPPORT BILATERAL PROCEDURE MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1680	PROCEDURE DOES NOT SUPPORT ASSISTANT SURGERY MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1681	PROCEDURE DOES NOT SUPPORT CO-SURGERY MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1682	PROCEDURE IS NOT VALID FOR PATIENT GENDER	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N431	Not covered with this procedure. Start: 11/05/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)
1683	PROCEDURE IS NOT VALID FOR PATIENT AGE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N431	Not covered with this procedure. Start: 11/05/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1720	PER LCD/NCD GUIDELINES,NONE OF THE DIAGNOSIS CODE(S) ON THE CLAIM LINE MEET MEDICAL NECESSITY FOR PROCEDURE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)
1721	PER LCD/NCD GUIDELINES,ONE OF THE DIAGNOSIS CODE(S) ON THE CLAIM LINE MEET MEDICAL NECESSITY FOR PROCEDURE CODE, HOWEVER IT IS NOT THE PRIMARY	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)
1722	PER LCD/NCD GUIDELINES,PRIMARY DIAGNOSIS CODE ON THE CLAIM LINE DOES NOT MEET MEDICAL NECESSITY FOR PROCEDURE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)
1723	PER LCD/NCD GUIDELINES,SECONDARY DIAGNOSIS CODE ON THE CLAIM LINE IS MISSING OR DOES NOT MEET MEDICAL NECESSITY FOR PROCEDURE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)
1724	PER LCD/NCD GUIDELINES,TERTIARY DIAGNOSIS CODE ON THE CLAIM LINE IS MISSING OR DOES NOT MEET MEDICAL NECESSITY FOR PROCEDURE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1725	PER LCD/NCD GUIDELINES,A REQUIRED MODIFIER IS NEEDED TO MEET MEDICAL NECESSITY FOR PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1726	PER LCD/NCD GUIDELINES,THE PATIENTS AGE DOES NOT MEET POLICY GUIDELINES FOR PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1727	PER LCD/NCD GUIDELINES,THE DIAGNOSIS CODE(S) DO NOT MEET CODE TO CODE DIAGNOSIS GUIDELINES FOR PROCEDURE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD. Start: 05/30/2002 | Last Modified: 07/01/2010 Notes: (Modified 4/1/04, 7/1/10)
1728	PER LCD/NCD GUIDELINES,A SPECIFIC MODIFIER IS NEEDED TO MEET POLICY GUIDELINES WHEN A CODE TO CODE RELATIONSHIP EXISTS WITH PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1729	PER LCD/NCD GUIDELINES,A ADDITIONAL PROCEDURE CODE IS NEEDED TO MEET POLICY GUIDELINES WHEN BILLING PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1730	PER LCD/NCD GUIDELINES,THE FREQUENCY FOR PROCEDURE CODE HAS BEEN EXCEEDED	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1731	PER LCD/NCD GUIDELINES,THE PLACE OF SERVICE DOES NOT MEET GUIDELINES FOR PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1732	PER LCD/NCD GUIDELINES,THE PATIENTS GENDER DOES NOT MEET GUIDELINES FOR PROCEDURE CODE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1733	PER LCD/NCD GUIDELINES,PROCEDURE CODE REQUIRES A SPECIFIC MODIFIER WHEN BILLED IN THIS PLACE OF SERVICE	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1735	THE SURGICAL PROCEDURE CODE HAS BEEN CROSSWALKED TO ANESTHESIA PROCEDURE CODE FOR EDITING OF THE CLAIM	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1736	PROCEDURE WAS BILLED BY A PROVIDER NOT LISTED AS AN ANESTHESIOLOGIST OR NURSE ANESTHESTIST. REVIEW PROVIDER FILE AND DOCUMENTION TO VERIFY APPROPRIATENESS	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service. Start: 07/31/2001 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1737	ONLY ALLOW THE ANESTHESIA CODE WITH THE HIGHEST VALUE PER OPERATIVE SESSION	269	Start: 01/01/1995 | Last Modified: 09/20/2009Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 03/01/2015	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment. Start: 01/01/1997 | Last Modified: 11/01/2010 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)
1738	THE BEGINNING OR ENDING DOS IS INVALID OR MISSING OR BEGINNING DOS IS GREATER THAN PATIENTS DOB	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N329	Missing/incomplete/invalid patient birth date. Start: 12/02/2004
1740	THE PLACE OR SERVICE IS MISSING OR INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M77	Missing/incomplete/invalid/inappropriate place of service. Start: 01/01/1997 | Last Modified: 03/14/2014 Notes: (Modified 2/28/03, 3/1/2014, 3/14/2014)
1742	PROCEDURE CODE NOT TYPICAL FOR AGE OF PATIENT	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1743	THE BEGINNING OR ENDING DOS IS INVALID OR MISSING OR BEGINNING DOS IS GREATER THAN PATIENTS DOB	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1744	PROCEDURE CODE HAS BEEN DELETED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1745	PROCEDURE CODE IS TYPICALLY CONSIDERED COSMETIC	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N383	Not covered when deemed cosmetic. Start: 04/01/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)
1746	PROCEDURE CODE IS INVALID, MISSING OR DISABLED	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M383	Not covered when deemed cosmetic. Start: 04/01/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)
1747	PROCEDURE CODE IS NOT TYPICALLY PERFORMED FOR A PATIENT WHOSE GENDER IS M	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1750	PATIENTS DOB IS MISSING/INVALID OR AFTER DOS	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N329	Missing/incomplete/invalid patient birth date. Start: 12/02/2004
1751	DISCREPANCY DETECTED BETWEEN NO OF UNITS AND SERVICE DATES	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M53	Missing/incomplete/invalid days or units of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1753	PROCODURE IS WITHIN THE GLOBAL PERIOD OF 30 DAYS OF PREV (HISTORY) PROCEDURE CODE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N525	These services are not covered when performed within the global period of another service. Start: 03/01/2010
1754	PROCODURE IS WITHIN THE GLOBAL PERIOD OF 90 DAYS OF PREV (HISTORY) PROCEDURE CODE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N525	These services are not covered when performed within the global period of another service. Start: 03/01/2010
1755	DIAGNOSIS CODE IS NOT TYPICAL FOR AGE OF PATIENT	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1756	NONE OF THE DIAGNOSIS CODES ON THIS CLAIM LINE ARE FREQUENTLY ASSOCIATED DIAGNOISIS FOR PROCEDURE CODE	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1757	DIAGNOSIS CODE IS INVALID OR INACTIVE	167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 06/30/2005 | Last Modified: 09/20/2009	M44	Missing/incomplete/invalid condition code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1758	THERE IS NO PRIMARY DIAGNOSIS FOR THIS PROCEDURE	125		M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1759	PROCEDURE CODE REQUIRES CROSSWALK TO ANESTHESIA CODE PRIOR TO EDITING, REPLACE SURGICAL CPT CODE WITH APPROPRIATE ANESTHESIA CODE	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M67	Missing/incomplete/invalid other procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N302
1760	DIAGNOSIS CODE IS A NON-SPECIFIC DIAGNOSIS AND REQUIRES A FOURTH /FIFTH DIGIT	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1761	MODIFIER COMBINATION CANNOT BE BILLED ON THE SAME LINE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N519	Invalid combination of HCPCS modifiers.
1762	MODIFIER IS INVALID OR DISABLED	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1763	PROCEDURE CODE IS CONSIDERED INVESTIGATIONAL OR EXPERIMENTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted. Start: 03/01/2013 | Last Modified: 07/01/2014
1764	DIAGNOSIS IS NOT TYPICAL FOR GENDER IS M	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1765	PROCEDURE CODE REQUIRES MODIFIER 26 WHEN BILLING FOR PROFESSIONAL COMPONENT IN PLACE OF SERVICE 22	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1766	MEDICARE STATUTORY PAYMENT RESTRICTION FOR ASSISTANTS AT SURGERY APPLIES TO PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N646	Reimbursement has been adjusted based on the guidelines for an assistant. Start: 07/15/2013
1767	PER MEDICARE GUIDELINES, THE USUAL PAYMENT ADJUSTMENT FOR BILATERAL PROCEDURES DOES NOT APPLY	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N644	Reimbursement has been made according to the bilateral procedure rule. Start: 07/15/2013
1768	PAYMENT FOR PROCEDURE CODE IS ALWAYS BUNDLED INTO PAYMENT FOR OTHER SERVICES NOT SPECIFIED AND NO SEPARATE PAYMENT IS MADE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 11/5/07)
1769	PROCEDURE CODE IS AN SERVICE FOR WHICH PAYMENT IS BUNDLED INTO PAYMENT FOR ANOTHER PHYSICIAN SERVICE BILLED ON THE SAME DAY BY SAME PROVIDER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 11/5/07)
1770	BILLING FOR CO-SURGEONS IS NOT PERMITTED FOR THE PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 11/5/2007)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1771	PROCEDURE CODE REQUIRES A REVIEW OF DOC TO ESTABLISH THE MEDICAL NECESSITY OF SURGICAL ASSISTANT	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1772	PROCEDURE CODE REQUIRES A REVIEW OF DOC TO ESTABLISH THE MEDICAL NECESSITY OF TWO SURGEONS	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1773	PROCEDURE CODE REQUIRES DOCUMENTATION TO ESTABLISH THE MEDICAL NECESSITY OF A SURGICAL TEAM	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)
1774	PROCEDURE CODE WITH AN ALLOWED DAILY FREQUENCY OF 1 HAS BEEN EXCEEDED FOR DOS	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N362	The number of Days or Units of Service exceeds our acceptable maximum. Start: 11/18/2005
1775	PROCEDURE CODE IS WITHIN THE GLOBAL PERIOD OF HISTORY PROCEDURE CODE - DIAGNOISIS INDICATES SAME CONDITION	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. Start: 10/31/2002 | Last Modified: 04/01/2007 Notes: (Modified 4/1/07)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1776	AN ASSISTANT SURGEON MODIFIER IS NOT APPROPRIATE FOR PROCEDURE CODE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1777	MEDICARE CONSIDERS PROCEDURE CODE AS A BUNDLED SERVICE WHEN OTHER PAYABLE SERVICES ARE BILLED ON THE SAME DAY BY SAME PRV	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013
1778	PROCEDURE CODE DOES NOT TYPICALLY REQUIRE PERFORMANCE BY PHYSICIAN IN PLACE OF SERVICE	170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 06/30/2005 | Last Modified: 09/20/2009	n/a	
1779	PROCEDURE CODE IS NOT COVERED BY MEDICARE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1780	PROCEDURE CODE IS NOT VALID FOR MEDICARE PURPOSES	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1781	USE OF MODIFIER IS NOT TYPICAL FOR PROCEDURE CODE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1782	REVIEW PROCEDURES FOR POSSIABLE MULTIPLE REDUCTION OR PAYMENT ADJUSTMENT	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/	n/a	
1783	PROCEDURE CODE IS A PHYSICAL THERAPY SERVICE, NOT PAYMENT IS MADE DUE TO PLACE OF SERVICE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1784	TEAM SURGERY IS NOT PERMITTED FOR PROCEDURE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301
1785	HISTORY PROCEDURE CODE HAS A UNBUNDLED RELATIONSHIP	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1786	PROCEDURE WAS BILLED ON SAME DAY AS AN E/M CODE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1787	DIAGNOSIS CODE DESCRIBES AN EXTERNAL CAUSE OR REQUIRES THE ICD CODE FOR FIRST UNDERLYING DISEASE	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1788	PATIENT RECEIVED CARE BY PROVIDER WITHIN THE LAST THREE YEARS - ESTABLISHED PATIENT E/M CODE SHOULD BE PAID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
1790	MODIFIER 26 IS NOT APPROPRIATE WITH PROCEDURE CODE - PROCEDURE IS DEFINED AS 100% PROFESSIONAL OR TECHNICAL	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
1791	PROCEDURE CODE WAS UNBUNDLED	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1792	PROCEDURE CODE IS NOT TYPICALLY PERFORMED BY A PHYSICIAN AT PLACE OF SERVICE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1793	A PROCEDURE REDUCTION HAS BEEN APPLIED FOR ASSISTANT SURGEON OR CO-SURGEON OR TEAM SURGERY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N646	Reimbursement has been adjusted based on the guidelines for an assistant. Start: 07/15/2013
1794	PRE-OP SERVICE PERFORMED 1 DAY BEFORE OR SAME DAY AS A HISTORY SURGICAL PROCEDURE CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 01/01/1997
1795	HISTORY PRE-OP E/M SERVICE PERFORMED 1 DAY BEFORE OR SAME DAY AS A HISTORY SURGICAL PROCEDURE CODE IS NOT ALLOWED AS PART OF GLOBAL PACKAGE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 01/01/1997
1799	PROCEDURE CODE TYPICALLY REQUIRES NOT SURGICAL ASSISTANT	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1800	DIAGNOSIS CODE COULD INVOLVE THIRD-PARTY LIABILITY AND/OR SUBROGATION OF BENEFITS	215	Based on subrogation of a third party settlement Start: 01/27/2008	n/a	
1801	PROCEDURE CODE IS AN UNLISTED PROCEDURE OR SERVICE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1812	OTHER PROCEDURE CODE IS NOT VALID FOR DATE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301
1964	N434-MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR - 1964	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 07/01/2008
1977	29 - THE TIME LIMIT FOR FILING HAS EXPIRED(MEDICARE)	29	The time limit for filing has expired. Start: 01/01/1995	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
1978	29 - THE TIME LIMIT FOR FILING HAS EXPIRED(MEDI-CAL)	29	The time limit for filing has expired. Start: 01/01/1995	n/a	
1996	CCI (OR OCE) INCIDENTAL PROCEDURE; SHOULD NOT BE REIMBURSED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
1997	CCI (OR OCE) MUTUALLY EXCLUSIVE PROCEDURE; SHOULD NOT BE REIMBURSED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
2002	UPN IS REQUIRED FOR THE PROCEDURE CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M99	Missing/incomplete/invalid Universal Product Number/Serial Number. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2006	DUPLICATE OF IN PROCESS CLAIM	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N522	Duplicate of a claim processed, or to be processed, as a crossover claim. Start: 11/01/2009 | Last Modified: 03/01/2010

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
2008	NDC IS REQUIRED FOR PROCEDURE CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). Start: 01/01/1997 | Last Modified: 04/01/2007 Notes: (Modified 2/28/03, 4/1/04)
2010	PCN MATCH FOUND, DUPLICATE OF IN PROCESS CLAIM	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N522	Duplicate of a claim processed, or to be processed, as a crossover claim. Start: 11/01/2009 | Last Modified: 03/01/2010
2015	CLAIM RETURNED TO PROVIDER FOR CORRECTION (RTP) (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N463	Missing support data for claim. Start: 07/01/2008
2016	CLAIM REJECTED (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N463	Missing support data for claim. Start: 07/01/2008
2017	CLAIM DENIED (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N463	Missing support data for claim. Start: 07/01/2008

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
2018	CONDITION CODE 21 (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M44	Missing/incomplete/invalid condition code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2019	INVALID FROM/THRU DATES (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M52	Missing/incomplete/invalid "from" date(s) of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2021	INVALID AGE (EASYGroup)	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
2022	INVALID SEX (EASYGroup)	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
2023	ONLY INCIDENTAL SERVICES REPORTED (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N19	Procedure code incidental to primary procedure. Start: 01/01/2000

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
2024	PARTIAL HOSPITALIZATION SERVICES,NON-MENTAL-HEALTH DIAGNOSIS (EASYGroup)	11	non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S	n/a	
2025	INSUFFICIENT PARTIAL HOSPITALIZATION SERVICES (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2026	PARTIAL HOSPITALIZATION SERVICE WITH PAYSTATUS T SERVICE (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2027	PARTIAL HOSPITALIZATION < 4 DAYS WITH INSUFFICIENT OR INAPPROPRIATE SERVICES (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M53	Missing/incomplete/invalid days or units of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2028	PARTIAL HOSPITALIZATION > 3 DAYS WITH INSUFFICIENT PHP SERVICES (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M53	Missing/incomplete/invalid days or units of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
2029	PARTIAL HOSPITALIZATION > 3 DAYS WITH INAPPROPRIATE SERVICES (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M53	Missing/incomplete/invalid days or units of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2030	ONLY MENTAL HEALTH EDUCATION AND TRAINING SERVICES ARE PROVIDED DURING ONE OR MORE DAYS (EASYGroup)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M53	Missing/incomplete/invalid days or units of service. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2031	EXTENSIVE MENTAL HEALTH SERVICES PROVIDED PAYSTATUS T SERVICE (EASYGroup)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M42	The medical necessity form must be personally signed by the attending physician. Start: 01/01/1997
2032	PARTIAL HOSPITALIZATION CONDITION CODE INVALID FOR THIS BILL TYPE (EASYGroup)	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2035	NDC VALUE IS INVALID	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). Start: 01/01/1997 | Last Modified: 04/01/2007 Notes: (Modified 2/28/03, 4/1/04)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
2159	PROCEDURE TO DIAGNOSIS PROCEDURE DENIED (CLAIM REVIEW)	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M64	Missing/incomplete/invalid other diagnosis. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
2160	MEDICALLY UNNECESSARY PROCEDURE DENIED (CLAIM REVIEW)	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	n/a	
8015	PROVIDER IS UNDER INVESTIGATION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N665	Services by an unlicensed provider are not reimbursable. Start: 07/15/2013
8016	NON-COVERED BENEFIT FOR THIS PLAN	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
8020	REPORTING CODE/INFORMATIONAL	246	This non-payable code is for required reporting only. Start: 09/30/2012	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8021	SERVICE NOT AUTHORIZED	39	Services denied at the time authorization/pre-certification was requested. Start: 01/01/1995	n/a	
8028	HCAPP - APPEAL REC'D, HCI DECISION OVERTURNED ON APPEAL	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	MA91	Alert: This determination is the result of the appeal you filed. Start: 01/01/1997 | Last Modified: 07/01/2015 Notes: (Modified 7/1/15)
8029	HCASR - REDUCTION FOR ASSISTANT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N646	Reimbursement has been adjusted based on the guidelines for an assistant. Start: 07/15/2013
8030	HCCPD - DUPLICATE SRVS PAID TO ANOTHER PROV ON SAME DAY	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated. Start: 02/28/2002
8031	HCCSR - REDUCE, SURGICAL TEAM	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	MA67	Alert: Correction to a prior claim. Start: 01/01/1997 | Last Modified: 11/01/2015 Notes: (Modified 11/1/2015)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8032	HCEFR - ENDOSCOPIC FAMILY REDUCTION	203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	n/a	
8033	HCFRE - REIMBURSABLE FOR CERTAIN QTY BASED ON DX	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N640	Exceeds number/frequency approved/allowed within time period. Start: 07/15/2013
8040	HCRME - ADJUSTMENT MADE TO A MUTUALLY EXCLUSIVE CODE	231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 07/01/2009 | Last Modified: 09/20/2009	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed. Start: 07/15/2013
8041	HCRUP - ADJUSTMENT FOR REVERSE UNBUNDLED CODE	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013
8042	HCACW - ANESTHESIA CODE INCORRECTLY CODED AS SURGERY	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	M67	Missing/incomplete/invalid other procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N302

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8043	HCADD - ADD-ON CODE DENIED AS PRIMARY CODE WAS DENIED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8044	HCAGE - INAPPROPRIATE FOR AGE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N129	Not eligible due to the patient's age. Start: 10/31/2002 | Last Modified: 08/01/2007 Notes: (Modified 8/1/07)
8045	HCAGM - ROUTINE ANTEPARTUM SRVCS INCLUDED IN GLOBAL CODE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N61	Rebill services on separate claims. Start: 01/01/2000
8046	HCASM - ASST SURGEON PROC CODE DOES NOT MATCH PRIMARY SURG	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301
8047	HCASP - ASSISTANT BILL W/O SURGEONS BILL	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N248	Missing/incomplete/invalid assistant surgeon name.

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8048	HCAWP - ANESTHESIA NO SURGEON	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N249	Missing/incomplete/invalid assistant surgeon primary identifier.
8049	HCBILL - BILATERAL CODE INAPPROPRIATE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8050	HCCOS - COSMETIC PROCEDURE IS NOT COVERED	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N383	Not covered when deemed cosmetic. Start: 04/01/2007 | Last Modified: 03/08/2011 Notes: (Modified 3/8/11)
8051	HCCPD - DUPLICATE SERVICE BILLED BY ANOTHER PROVIDER SAME DAY	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	n/a	
8052	HCCRE - PROVIDER CREDENTIALS ARE NOT VALID FOR BILLING	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N665	Services by an unlicensed provider are not reimbursable. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8053	HCCSA - CO-SURGEON NOT ALLOWED	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N522	Duplicate of a claim processed, or to be processed, as a crossover claim. Start: 11/01/2009 | Last Modified: 03/01/2010
8054	HCDUP - DUPLICATE OF A PREVIOUSLY PAID CLAIM LINE	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	N522	Duplicate of a claim processed, or to be processed, as a crossover claim. Start: 11/01/2009 | Last Modified: 03/01/2010
8055	HCELG - PATIENT NOT ELIGIBLE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N30	Patient ineligible for this service. Start: 01/01/2000 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)
8056	HCFOT - FREQUENCY OVER TIME EXCEEDED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N640	Exceeds number/frequency approved/allowed within time period. Start: 07/15/2013
8057	HCFRE - REIMBURSABLE FOR CERTAIN QTY BASED ON CODE OR DX	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8058	HCFUD - SRVCS INCLUDED IN GLOBAL SURG PKGE OF ANOTHER ARVC	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. Start: 04/01/2007 | Last Modified: 07/01/2015 Notes: (Modified 7/1/15)
8059	HCGDR - ANTEPARTUM CARE INCLUDED IN GLOBAL OB CODE	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. Start: 04/01/2007 | Last Modified: 07/01/2015 Notes: (Modified 7/1/15)
8060	HCGEN - INCORRECT PATIENT GENDER	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
8061	HCGPA - SRVCS INCLUDED IN GLOBAL SURG PKGE OF ANOTHER SRVC	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 01/01/1997
8063	HCIOP - INPATIENT ONLY PROCEDURES (IOP)	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M50	Missing/incomplete/invalid revenue code(s). Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8064	HCLIF - SRVCS BILLED MORE THAN TYPICALLY ALLOWED - LIFETIME	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N117	This service is paid only once in a patient's lifetime. Start: 07/30/2002 | Last Modified: 06/30/2003 Notes: (Modified 6/30/03)
8065	HCMAT - OB CODES BILLED INCORRECTLY; INCLUDED IN GLOBAL SRVC	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N61	Rebill services on separate claims. Start: 01/01/2000
8066	HCMAX - CODE BILLED EXCEEDS DAILY LIMITS	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N362	The number of Days or Units of Service exceeds our acceptable maximum. Start: 11/18/2005
8067	HCMEX - MUTUALLY EXCLUSIVE CODES ARE NOT PAYABLE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8068	HCMOD - INAPPRORIATE USE OF MODIFIER 26	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N13	Payment based on professional/technical component modifier(s). Start: 01/01/2000

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8069	HCMTC - INAPPROPRIATE USE OF TC MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
8070	HCNCS - SERVICE OR CODE NOT COVERED BY PLAN	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8072	HCNPR - NEW E&M NOT BILLABLE; REBILL WITH EST PATIENT CODE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013
8073	HCNPT - NEW E&M NOT BILLABLE; REBILL WITH EST PATIENT CODE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013
8074	HCOBS - HCPCS CODE NOT PAYABLE WITH OBSERVATION REV CODE	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. Start: 01/30/2011 | Last Modified: 07/01/2013	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8076	HCPDM - PROCEDURE NOT ALLOWED WITH REPORTED DIAGNOSIS	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	n/a	
8077	HCPED - PROCEDURE TO EXCLUDED DIAGNOSIS MISMATCH	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	n/a	
8078	HCPRD - PROCEDURE TO EXCLUDED DIAGNOSIS MISMATCH	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	n/a	
8079	HCPRQ - A HCPCS/CPT CODE IS REQUIRED WITH THIS REVENUE CODE	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013
8080	HCPS1 - PRIMARY SERVICE WHEN MULTI SRVCS BILLED ON SAME DAY	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M51	Missing/incomplete/invalid procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N301

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8081	HCPST - POSTPARTUM SERVICES INCLUDED IN GLOBAL CODE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N61	Rebill services on separate claims. Start: 01/01/2000
8082	HCRAS - PRIMARY SURG AND ASST SURG NOT BILLED WITH SAME CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8083	HCRBP - CODES BILLED REPRESENT A SINGLE GLOBAL CODE ; REBILL	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N130	Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 | Last Modified: 11/01/2009 Notes: (Modified 4/1/07, 7/1/08, 11/1/09)
8084	HCRDS - DUPLICATE SRVCS BILLED IN SAME RANGE OF CODES	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013	n/a	
8085	HCREB - CODES BILLED REPRESENT A SINGLE GLOBAL CODE ; REBILL	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009	N130	Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 | Last Modified: 11/01/2009 Notes: (Modified 4/1/07, 7/1/08, 11/1/09)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8086	HCRME - ADJUSTMENT MADE TO A MUTUALLY EXCLUSIVE CODE	231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 07/01/2009 | Last Modified: 09/20/2009	n/a	
8087	HCRUP - ADJUSTMENT FOR REVERSE UNBUNDLED CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 01/01/1997
8088	HCSAS - ASSISTANT SURGEON NOT ALLOWED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N646	Reimbursement has been adjusted based on the guidelines for an assistant. Start: 07/15/2013
8089	HCSUS - DOCUMENTATION NEEDED FOR PROCESSING; RESUBMIT W/CLM	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M29	Missing operative note/report. Start: 01/01/1997 | Last Modified: 07/01/2008 Notes: (Modified 2/28/03, 7/1/2008) Related to N233
8090	HCTSA - TEAM SURGERY NOT ALLOWED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8091	HCUNB - DENIED CODE IS UNBUNDLED	B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016 Notes: This code has been replaced by 272 and 273.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions. Start: 07/15/2013
8092	HCUNL - UNLISTED CODE NOT ALLOWED; REBILL WITH SPECIFIC CODE	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. Start: 08/01/2005 | Last Modified: 07/01/2008 Notes: (Modified 7/1/08)
8094	CALIFORNIA CHILDREN'S SERVICES	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	n/a	
8128	MEMBER NOT FOUND	26	Expenses incurred prior to coverage. Start: 01/01/1995	N650	This policy was not in effect for this date of loss. No coverage is available. Start: 07/15/2013
8132	CODE NOT COVERED BY MEDICARE;	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary. Start: 07/15/2013

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8133	ONLY COVERED WHEN CLAIM SUBMIT with R&B	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 01/01/1997
8137	PROVIDER NOT FOUND	147	Provider contracted/negotiated rate expired or not on file. Start: 06/30/2002	N252	Missing/incomplete/invalid attending provider name. Start: 12/02/2004
8138	CODE REQUIRES MODIFIER	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N517	Resubmit a new claim with the requested information. Start: 03/01/2009
8143	CLAIM FORWARDED TO PROVIDER 4284	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
8144	VACCINATION FOR CHILDREN <=18	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 01/01/1997

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8145	NOT ACC BENEFIT; PROCESSED UNDER MCAL BENEFIT	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary. Start: 07/15/2013
8147	CODE IS NOT USABLE FOR BILLING OB SERVICES PER NEW GUIDELINE EFF 05/01/11	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 01/01/2000 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8148	PROFESSIONAL SERVICE NOT BILLABLE BY A FACILITY	5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service. Start: 01/01/1997 | Last Modified: 03/14/2014 Notes: (Modified 2/28/03, 3/1/2014, 3/14/2014)
8149	REBILL PROFESSIONAL SERVICES TO COMMUNITY HEALTH CENTER NETWORK	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	n/a	
8150	REBILL PROFESSIONAL SERVICES TO CHILDREN FIRST MEDICAL GROUP	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8170	CODE NOT COVERED BY MCAL	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
8174	PREVENTIVE CARE DIAGNOSIS CODE REQUIRED	125		M76	Missing/incomplete/invalid diagnosis or condition. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8176	PLEASE RE-SUBMIT WITH BILLED CHARGES	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M54	Missing/incomplete/invalid total charges. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8177	NTIME: ANESTHESIA TIME NOT SUBMITTED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N203	Missing/incomplete/invalid anesthesia time/units. Start: 06/30/2003 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)
8178	NRMOB: Normal delivery: indicate TBT w/patient & resubmit.	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N203	Missing/incomplete/invalid anesthesia time/units. Start: 06/30/2003 | Last Modified: 03/14/2014 Notes: (Modified 3/14/2014)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8179	AUTHD SERV CODES DO NOT MATCH PROC/REV CODES ON CLAIM; CONTACT UM DEPT FOR APPEAL	197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	N188	The approved level of care does not match the procedure code submitted. Start: 02/28/2003
8180	PRIVATE RM AND BD REVCODES ARE NOT COVERED BY AAH	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	N657	This should be billed with the appropriate code for these services. Start: 07/15/2013
8184	CLAIM FORWARDED TO MARCH VISION (4273)	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. Start: 04/01/2004 | Last Modified: 03/14/2014 Notes: (Modified 3/1/2010, 3/14/2014)
8185	DME CAPITATED SERVICES CHME	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 8/1/06, 11/5/07)
8186	QUEST CAPITATED SERVICES	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. Start: 01/01/1997 | Last Modified: 11/05/2007 Notes: (Modified 8/1/06, 11/5/07)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8187	THIS IS A CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8206	IMPLANT SERVICE REQUIRES INVOICE	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Start: 09/30/2012 | Last Modified: 06/02/2013	M23	Missing invoice. Start: 01/01/1997 | Last Modified: 08/01/2005 Notes: (Modified 8/1/05)
8210	VACCINE FOR CHILDREN ADMIN CPT NOT PAYABLE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 01/01/1997
8211	CLAIM DENIED DUE TO INCORRECT GROUP NPI	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	N43	Bed hold or leave days exceeded. Start: 01/01/2000
8212	THE ICD-9 DIAGNOSIS/PROCEDURE CODE CANNOT BE USED ON OR AFTER DATES OF SERVICE OCTOBER 1, 2015	N146		N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html Start: 03/01/2015 | Stop: 11/01/2016 | Last Modified: 11/01/2015 Notes: (Modified 11/1/2015)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8213	THE ICD-9 DIAGNOSIS/PROCEDURE CODE CANNOT BE USED ON OR AFTER DISCHARGE DATE OF OCTOBER 1, 2015	N146		N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html Start: 03/01/2015 | Stop: 11/01/2016 | Last Modified: 11/01/2015 Notes: (Modified 11/1/2015)
8214	THE ICD-10 DIAGNOSIS/PROCEDURE CODE CANNOT BE USED BEFORE DATES OF SERVICE OF OCTOBER 1, 2015	N146		N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html Start: 03/01/2015 | Stop: 11/01/2016 | Last Modified: 11/01/2015 Notes: (Modified 11/1/2015)
8215	THE ICD-10 DIAGNOSIS/PROCEDURE CODE CANNOT BE USED BEFORE DISCHARGE DATE OF OCTOBER 1, 2015	N146		N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html Start: 03/01/2015 | Stop: 11/01/2016 | Last Modified: 11/01/2015 Notes: (Modified 11/1/2015)
8216	OTHER PROCEDURE CODE IS REQUIRED	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 11/01/2013	M67	Missing/incomplete/invalid other procedure code(s). Start: 01/01/1997 | Last Modified: 12/02/2004 Notes: (Modified 12/2/04) Related to N302
482	Auth ID not found.	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8212	AUTHORIZATION UNIT'S EXCEEDED	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
482	Auth ID not found.	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8212	AUTHORIZATION UNIT'S EXCEEDED	198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	M62	Missing/incomplete/invalid treatment authorization code. Start: 01/01/1997 | Last Modified: 02/28/2003 Notes: (Modified 2/28/03)
8500	CLAIM PAID AT CONTRACTED RATE OR FEE SCHEDULE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) This change effective 3/1/2016: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	n/a	
8217	CLAIM FORWARDED BEACON PRV 4284-	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8192	RESPONSIBILITY OF PROVIDER - CHILDREN'S FIRST MEDICAL GROUP	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8199	RESPONSIBILITY OF PROVIDER – KAISER	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8200	RESPONSIBILITY OF PROVIDER - BEACON HEALTH STRATEGIES	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8201	RESPONSIBILITY OF PROVIDER - COMMUNITY HEALTH CENTER NETWORK	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8202	RESPONSIBILITY OF PROVIDER - MARCH VISION	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8500	CLAIM PAID AT CONTRACTED RATE OR FEE SCHEDULE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note:	n/a	
8217	CLAIM FORWARDED BEACON PRV 4284-	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	n/a	
8192	RESPONSIBILITY OF PROVIDER - CHILDREN'S FIRST MEDICAL GROUP	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2008	n/a	
8199	RESPONSIBILITY OF PROVIDER – KAISER	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2009	n/a	
8200	RESPONSIBILITY OF PROVIDER - BEACON HEALTH STRATEGIES	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2010	n/a	

HS Claim MS ID	HS Claim MSG ID Description	Claim Adj. Reason Cd (CARC)	Description	Remittance Adj. Reason Cd. (RARC)	Description
8201	RESPONSIBILITY OF PROVIDER - COMMUNITY HEALTH CENTER NETWORK	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2011	n/a	
8202	RESPONSIBILITY OF PROVIDER - MARCH VISION	24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2012	n/a	