AmeriHealth Caritas Pennsylvania - AmeriHealth Caritas Northeast - AmeriHealth Caritas VIP Care

New and Current Explanation of Benefit (EOB) Codes - Effective June 1, 2020

You may begin to see additional Explanation of Benefits (EOB) codes on zero paid lines. In the past, edits were applied after the payment was calculated. Starting in 2020, our new process applies correct coding and billing edits before pricing. This change resulted in a new set of EOB codes; the new codes begin with a lower case alpha value and the current EOB codes begin with an upper case alpha value.

This list includes new and current EOB codes.

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
p01	A required procedure code or modifier is missing or invalid on the current line or an associated claim line	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
p02	The patient's age or gender conflicts with the procedure and/or diagnosis code	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
p03	A diagnosis code which meets medical necessity for this procedure code is missing or invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
p04	Documentation or authorization is required to be submitted and/or reviewed	197	Precertification/authorization/notification/pre-treatment absent.	N/A	N/A: No Additional Specification Needed	CO
p05	This is a possible duplicate claim line of another claim line in history	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A: No Additional Specification Needed	CO
p06	This E/M procedure code is inappropriately reported for an established or new patient	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
p07	The units have exceeded the allowable maximum frequency per time span	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
p08	The required modifier is missing or the modifier is invalid for the procedure code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
p09	This is a non-covered, restricted, reporting only, or bundled procedure code 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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
p10	The place of service code is missing or invalid for the procedure code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
p11	The provider specialty is missing or invalid for the place of service or procedure code	299	The billing provider is not eligible to receive payment for the service billed.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO
p12	A procedure reduction should be applied to this claim line based on the procedure code or modifier submitted	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	CO
p13	The type of bill, procedure code, or revenue code are conflicting	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA60	Missing/incomplete/invalid patient relationship to insured.	CO
p14	The procedure code has an unbundle relationship with another procedure on this claim or on a claim in history	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
p15	This claim or claim line is missing information which is needed for editing	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
p16	There is a conflict with the occurrence, value or condition code and the procedure, revenue code or TOB on the claim	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO
s01	The patient status is not valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.	CO
s02	The patient status code is missing.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.	CO
s05	Procedure codes 02RK0JZ and 02RL0JZ are limited coverage when Z006 diagnosis code is present.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
s06	The Other diagnosis code indicates that a wrong procedure was performed.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
s07	The Principal diagnosis code indicates that a wrong procedure was performed.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
s08	Procedure code 9672 should not be reported when the patient's length of stay is less than four days	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
s10	Non-exempt facility submitted principle diagnosis code with Hospital Acquired Condition	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
s12	The Principal diagnosis code requires a non-exempt POA indicator of 1 or X	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
s14	Non-exempt facility submitted other diagnosis code with Hospital Acquired Condition	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
t15	E/M code billed on a date of service as a minor or major procedure without an appropriate modifier.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
t22	Add-on procedure code has been submitted without appropriate primary procedure	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.	CO
t23	Procedure code is a non-covered service per the Non-covered Service list	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
t24	Add-on procedure code has been submitted without an appropriate primary procedure code	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.	CO
t26	Medicare: Only intraoperative portion of global payment is allowed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t27	Medicare: Only postoperative portion of global payment is allowed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
t28	Medicare: Only intraoperative portion of global payment is allowed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t29	Medicare: Only intraoperative portion of global payment is allowed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t30	Medicare: The units for this service exceeds the allowed units.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO
t31	The presence of an anesthesia modifier indicates a reduction in payment	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
t32	Anesthesia code on this line requires an appropriate modifier.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t33	Medicare:Professional component modifier needed in place of service for this diagnostic procedure code.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t34	Per the MPFS, procedure code describes the physician services. Use of a modifier is not appropriate.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
t35	Per the MPFS, procedure code describes only the technical portion of a service or diagnostic test. A modifier is not appropriate.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t36	Per the MPFS, procedure code describes the global code of a service or diagnostic test. The modifier is not appropriate.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t37	Per the MPFS, procedure code describes a physician interpretation for service and is not appropriate in place of service	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
t38	Per the MPFS, procedure code describes the physician work portion of a diagnostic test. The modifier is not appropriate.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t39	Per Medicare guidelines, procedure code is a service covered incident to a physician's service and modifier is not appropriate.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t40	Per Medicare, use of a modifier is not typical for the billed procedure.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
t45	The procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates it is the same condition	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N/A	N/A: No Additional Specification Needed	CO
t46	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
t47	Per Medicare guidelines a history procedure code by the same provider is in the global period of the procedure code for the same condition	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t48	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
t50	Modifier GK cannot be submitted alone, another line with GA or GZ must be present on the same claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO
t51	The presence of modifier GY indicates this is not eligible for payment.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
t52	Per Medicare guidelines, the procedure code is a non covered code or the modifier is a non covered modifier.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
t53	Per Medicare these are non-covered services because this is not deemed a medical necessity by the payer.	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
t54	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
t56	Per Medicare, a history procedure code is within the global period of the procedure code on this line	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t57	The date of service is past Medicare timely filing guidelines.	29	The time limit for filing has expired.	N/A	N/A: No Additional Specification Needed	CO
t58	Per Medicaid Medically Unlikely Edits, the units of service billed for the procedure code exceed the allowed number of units.	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
t60	Per Medicaid NCCI edits, the procedure code has an unbundle relationship with a code in history	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
t62	The Diagnosis code and modifier combination are inappropriate	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
t63	Per Medicare guidelines, the procedure code has an unbundle relationship with a history procedure code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
t66	Per Medicare, procedure is identified as an ambulance code and requires an ambulance modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
t67	The presence of modifier GZ indicates this is not eligible for payment.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO
w15	Whole blood revenue codes can only be used when billing for whole blood.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
w16	Billed HCPCS code is not approved for a partial hospitalization claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO
w17	Billed HCPCS code can only be billed on a partial hospitalization claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w18	Charge exceeds token charge ($1.01).	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing/incomplete/invalid charge.	CO
w20	Per CMS Medically Unlikely Edits, the units billed for submitted procedure code exceed the defined allowable units.	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w23	Per LCD or NCD guidelines, procedure code has a denied relationship.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	CO
w38	Per Medicaid NCCI edits, a history procedure has an unbundle relationship with the procedure code on this line	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
w39	Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history	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.	N/A	N/A: No Additional Specification Needed	CO
w40	The Statement Covers Period Through Date of Service is past the Medicare facility timely filing limit.	29	The time limit for filing has expired.	N/A	N/A: No Additional Specification Needed	CO
w42	The HCPCS add-on code 33225 is lacking a required primary code on the claim.	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.	CO
w55	The surgical procedure code contains a terminated modifier and should be reviewed for a 50% reduction.	182	Procedure modifier was invalid on the date of service.	N/A	N/A: No Additional Specification Needed	CO
w57	Age and gender conflict; the Admission diagnosis code is not permissible for the patient's age and gender	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w58	Age and gender conflict; the Other diagnosis code is not permissible for the patient's age and gender.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
w59	Age and gender conflict; the Principal diagnosis code is not permissible for the patient's age and gender.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
w60	The Admission diagnosis code is invalid because it has an incomplete number of digits.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
w61	The Admission diagnosis code is invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
w62	The Admission diagnosis code is missing	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO
w64	The Other diagnosis code is invalid because it has an incomplete number of digits.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
w65	The Other procedure code must contain a fourth or fifth digit in order to be valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w66	The Other diagnosis code must be valid and is effective based on the through date on the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
w67	The Other procedure code must be in the ICD-PSC code Table.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).	CO
w70	The Principal diagnosis code does not contain a complete number of digits.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w71	The Principal procedure code must be complete in order to be valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.	CO
w72	The Principal diagnosis code is not valid based on the 'through' date on the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w73	The Principal procedure code must be in the ICD-PSC code Table.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.	CO
w74	The Principal diagnosis code is missing on the claim	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w77	The Other diagnosis code is a duplicate of another Other diagnosis code on the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
w78	Age conflict; the Admission diagnosis is not permissible for the patient's age.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w79	Age conflict; the Other diagnoses is not permissible for the patient's age.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w80	Age conflict; the Principal diagnosis is not permissible for the patient's age.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w81	Gender conflict; the patient's gender and Admission diagnosis code, on the claim are not permissible.	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w82	Gender conflict; the patient's gender and other diagnosis code, on the claim are not permissible.	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w83	Gender conflict; the patient's gender and Other procedure code on the claim are not permissible.	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w84	Gender conflict; the patient's gender and Principal diagnosis code, on the claim are not permissible.	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w85	Gender conflict; the patient's gender and Principal procedure code, on the claim are not permissible.	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
w87	Manifestation codes cannot be used as the Principal diagnosis.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w88	Principal diagnosis code indicates a questionable admission.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w89	Diagnosis code is unacceptable as a principal diagnosis unless a required secondary diagnosis is included on the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w90	Diagnosis code is unacceptable as a principal diagnosis.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w91	An E-code cannot be used as the Admission diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
w92	An E-code cannot be used as the Principal diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
w93	A non-covered over age 60 ICD procedure code is on the claim and the patient is older than 60 years of age.	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
w94	Procedure code is non-covered when a designated diagnosis code is 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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.	CO
w95	Procedure code is non-covered unless the exemption ICD-9 Procedure code or exemption ICD Diagnosis code is 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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.	CO
w97	Age invalid; Must be in range 0-124 years.	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
w98	The patient gender is missing.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.	CO
w99	The Patient Gender is invalid. Gender must be M, F, or U.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
x82	Units > 1 for bilateral procedure with modifier 50	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.	CO
x84	Revenue code 068X and CPT code 99291 not submitted on the same date of service as G0390	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO
y01	The account ID field is missing or invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
y03	The FTD edit validates the From (Admission) and Through (Discharge) Dates at the Claim level	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
y04	The CCA edit verifies that the condition code(s) on the claim are valid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO
y05	The PSC edit identifies claims that are missing or contains an invalid Patient Discharge Status Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y07	The TOB edit identifies claims that are missing or contains an invalid Type of Bill	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.	CO
y08	The VAL edit confirms that the Value Codes on the claim are valid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
y09	The ICMf edit validates that the claim contains the required primary diagnosis prior to HSS processing	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
y10	The PATf edit identifies a claim that has a missing Patient ID. Analysis cannot be performed without a Patient ID	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.	CO
y11	The DOBf edit identifies a claim that has a missing or invalid DOB. Certain edits cannot be performed without the patient DOB	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N329	Missing/incomplete/invalid patient birth date.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y13	This edit identifies a claim missing a Provider ID. Analysis cannot be performed without a Provider ID	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N77	Missing/incomplete/invalid designated provider number.	CO
y15	The OCC edit validates that the occurrence codes on the claim are valid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).	CO
y16	The OSC edit validates that the occurrence span codes on the claim are valid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M46	Missing/incomplete/invalid occurrence span code(s).	CO
y18	The TOA edit identifies claims that contain an invalid Type of Admission code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA41	Missing/incomplete/invalid admission type.	CO
y19	Identifies line items that are potentially duplicates when two lines entered on one or more claims have identical submitted data	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A: No Additional Specification Needed	CO
y21	Identifies an entire inpatient claim that is a potential duplicate of a previously submitted inpatient claim	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y23	This edit occurred because the first listed diagnosis field is blank or any diagnosis code is not valid for the service dates on the claim	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
y24	This edit occurred because the diagnosis code includes an age range and the patient age is outside of that range	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
y25	This edit occurred because the diagnosis code includes sex designation and the patient sex does not match	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
y27	This edit occurred because the first letter of the first listed diagnosis code is an E	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At	M64	Missing/incomplete/invalid other diagnosis.	CO
y28	This edit occurred because the submitted HCPCS code is not valid for the service dates on the claim	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO
y30	This edit occurred because the procedure code includes sex designation and the patient sex does not match	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
y31	This edit occurred because the procedure code has a non-covered servi ce indicator, meaning that it is non-covered based on Medicare policy	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.	CO
y32	This edit occurred because the claim was submitted with Cond Code 21 indicating that the provider is requesting verification of denial	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y33	This edit occured because the claim was submitted with Condition Code 20	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO
y34	This edit occurred because the procedure code has a questionable covered svc indicator Medicare will cover only in certain conditions	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
y35	This edit occurred because a procedure code indicates a service N/C by Medicare based on the type of bill and condition codes on the claim	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
y39	This edit occurred because multiple exclusive bilat proc codes are present, 2 or more times on the same svc date, with or w/o mod 50	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.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO
y40	This edit occurred because the proc has been designated by Medicare as paystatus "C", the proc is not covered when performed as outpt	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
y43	This edit occurred because the procedure is identified as a compo nent of another proc also on the claim for the same service date	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
y44	This edit occurred because the procedure is identified as a component of another procedure also on the claim for the same service date	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y45	This edit occurred because one or more type T or S procs occur on the same day as a line item containing an E/M code without modifier 25	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N822	Missing procedure modifier(s).	CO
y46	This edit occurred because the modifier is not in the list of valid OPPS modifiers	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
y47	Only edits for valid modifiers; not specific to outpatient facility claims	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
y49	This edit occurred because the FROM date is prior to August 1, 2000	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid “from” date(s) of service.	CO
y50	This edit occurred because the age is non-numeric or outside the range of 0-124 years	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.	CO
y51	This edit occurred because patient sex has any alpha value but F or M, or any numeric entry that is outside the range of 0-2	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M19	Missing oxygen certification/re-certification.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y52	This edit occurred because the proc code indicator Not Recognized by Medicare-OPPS. Medicare will not accept code, but may accept alternate	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO
y53	This edit occurred because the principal diagnosis is not related to mental health on a partial hospitalization claim	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
y59	This edit occurred because a mental health education and/or training services but does not contain any svcs assigned to APC 323,324,or 325	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).	CO
y61	This edit occurred because mod 73 is present, an independent or conditional bilateral proc with mod 50 or a proc with units>1	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
y62	This edit occurred because the claim contains an implanted device, but no surgical or other service to implant the device	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.	CO
y65	This edit occurred because the proc is a component of another proc on the claim coded on the same day, without a qualifying NCCI mod	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
y66	This edit occurred because the proc is a component of another proc on the claim coded on the same day, without a qualifying NCCI mod	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y67	This edit occurred because the Revenue Code is not in Medicare's list of valid OPPS Revenue Codes	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
y68	This edit occurred because multiple medical visits are present on the same day with the same Revenue Code, without Condition Code G0	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A: No Additional Specification Needed	CO
y69	This edit occurred because a blood transfusion or exchange is coded but no blood product is coded	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.	CO
y70	This edit occurred because Rev code 762 (observation) is used with a HCPCS code that does not represent an observation svc	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO
y71	This edit occurred because services with service indicator "C" which are on Medicare's 'separate procedures' list	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M2	Not paid separately when the patient is an inpatient.	CO
y72	This edit occurred because TOB 12X or 14X is present with Condition Code 41	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO
y74	This edit occurred because claim line contains revenue center and charges center is one for which Medicare requires a HCPCS code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y75	This edit is assigned to all other claim lines when one or more claim lines received edit 018	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M20	Missing/incomplete/invalid HCPCS.	CO
y76	This edit occurred because a claim line contains a CPT/HCPCS code which is non-covered by Medicare based on statute	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.	CO
y79	This edit occurred because observation "G" codes (G0243, G0244) are billed on a claim with TOB not equal to 13X	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.	CO
y81	This edit occurred because HCPCS code beginning with the letter C is used with TOB that is not hospital outpt (12X, 13X, 14X)	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.	CO
y83	This edit occurred because no E/M visit the day of or the day before the observation and the date of observation is 12/31 or 1/1	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
y84	This edit occurred because code G0379 is present w/o code G0378 for same claim with bill type 13x	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y86	This edit occurred because mod CA is on more than 1 line with Service Indicator C and same line item DOS or mod CA with multiple units	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO
y87	This edit occurred because proc code reported has a status indicator of Y indicating item can only be billed to the DME Regional Carrier	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.	CO
y88	This edit occurred because proc is not reportable on an OPPS claim but may be accepted for other types of claims	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
y91	This edit occurred because the line item contains a revenue code not recognized by Medicare	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
y92	This edit occurred because the line item contains C9399, identifying a drug that received FDA approval but does not have a HCPCS assigned	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
y93	This edit occurred because the item, service, or procedure was administered or performed prior to the date of FDA approval	114	Procedure/product not approved by the Food and Drug Administration.	N/A	N/A: No Additional Specification Needed	CO
y94	This edit occurred because the item, service, or procedure was admin istered or performed prior to the eff date as specified in the NCD	181	Procedure code was invalid on the date of service.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
y95	This edit occurred because the item, service, or procedure was admin istered or performed outside a clinical trial period approved by CMS	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N721	This service is only covered when performed as part of a clinical trial.	CO
y96	This edit occurred because modifier CA has been reported and the patient status code in FL 22 is not 20 (expired)	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.	CO
y98	This edit occurred because a procedure code has a status indicator of M and not be reported when submitting to the fiscal intermediary	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N/A	N/A: No Additional Specification Needed	CO
y99	This edit occurred because blood products are billed with RC 39X and modifier BL without a line billed with RC 38X	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z04	This claim line is being disallowed because more than one anesthesia procedure code was billed on the same DOS	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N633	Additional anesthesia time units are not allowed.	CO
z06	This claim line is being disallowed because there is a missing or invalid beginning or ending date of service (DOS).	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO
z08	COB Automation Review Line EOB Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
z10	This claim line is being disallowed because the procedure code is not typical for the patients age.	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z11	This claim line is being disallowed because the procedure code has been deleted.	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
z12	This claim line is being disallowed because the procedure code is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
z13	This claim line is being disallowed because the procedure code is not typical for the patients gender.	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z15	This claim line is being disallowed because it is a duplicate of another claim line.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A: No Additional Specification Needed	CO
z16	This claim line is being disallowed because the patients date of birth is missing, invalid, or after the date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N329	Missing/incomplete/invalid patient birth date.	CO
z17	Claim line is being disallowed due to the number of units not mat ching the date span between the beginning and ending dates of service	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N345	Date range not valid with units submitted.	CO
z22	Claim line is disallowed because a surgical code was submitted w/ in the global period w/ a Dx from same category by the same provider.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
z24	A history claim line is disallowed because its procedure code is unbundled and is considered unbundled.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
z27	This claim line is being disallowed because one of the diagnosis codes is not typical for the patients age.	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
z29	A diagnosis code on the line is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
z30	This claim line is being disallowed because there is no primary diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO
z32	This claim line is being disallowed because the diagnosis code requi res a fourth and/or fifth digit to provide appropriate specificity.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
z34	A modifier on the line is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N823	Incomplete/Invalid procedure modifier(s).	CO
z35	This claim line is being disallowed because a diagnosis code is not typical for the patients gender.	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z36	The procedure code requires a modifier 26.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N822	Missing procedure modifier(s).	CO
z37	Claim line is being disallowed because Medicare typically does not allow reimbursement for surgical assistants on this procedure code	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
z48	This claim line is being disallowed because the injection service is bundled into other payable services when billed on the same DOS.	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N/A	N/A: No Additional Specification Needed	CO
z52	A modifier on the line is not typical for the procedure code.	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z56	This claim line is being disallowed because team surgeons are not permitted with this procedure code per Medicare.	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z57	Medicare UNB for History Line A history claim line is disallowed because its procedure code is	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z58	Medicare Unbundled Scenario This claim line is being disallowed because its procedure code is	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z59	Medicare Ventilator Mgmt A ventilation management service was billed on the same date as an	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO
z60	A non-primary diagnosis code was submitted as the primary diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
z61	This claim line is being disallowed because a new patient E&M service was billed for an established Patient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
z62	This claim line is being disallowed because the patient ID is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.	CO
z64	The place of service is not typical for the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
z66	This claim line is being disallowed because the pre-operative E&M was billed the day before or same day as a surgical procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z67	A history line is disallowed because a pre-operative E&M was billed the day before or same day as a surgical procedure in history.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
z68	This claim line is being disallowed because the provider ID is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N77	Missing/incomplete/invalid designated provider number.	CO
z69	The patient gender is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.	CO
z71	This claim line is being disallowed because only one surgical assistant is allowed per procedure code.	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
z72	This claim line is being disallowed because the procedure code does not typically allow an assistant surgeon modifier.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO
z74	A diagnosis code on the line is a possible third-party liability.	22	This care may be covered by another payer per coordination of benefits.	N/A	N/A: No Additional Specification Needed	CO
z78	The procedure code is unlisted.	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N/A	N/A: No Additional Specification Needed	CO
z79	This claim line is being disallowed because the procedure code is considered cosmetic.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N383	Not covered when deemed cosmetic.	CO
z80	This claim line is being disallowed because the procedure code is considered investigational or experimental.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	CO
Current EOB Codes						
H00	Bundled into Service Not Specified These services are either bundled into other services on the same day,	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
H01	Included in Primary Procedure This procedure has been included in the primary procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H02	Denied- Duplicate Service on Same Day The same or a similar procedure code was billed on the same date of	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H03	Included in E&M Service This service is included in the billed Evaluation and Management code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H04	Post-Op Follow Up Incl in Global Fee The procedure is included in the global surgical fee for a procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO
H06	No Assist Needed For This Procedure Procedure Denied. The procedure code billed does not require the	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO
H07	Add-On Code Requires Primary Service This procedure was denied because it is an add-on code that requires a	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.	OA
H08	Clinical Trial Requires Approp. DX Clinical Trial requires appropriate diagnosis.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
H09	Dx Code Not Coded to Highest Level The billed diagnosis code is not coded to the highest level of	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M81	You are required to code to the highest level of specificity.	CO
H10	submit with individual provider Please submit with individual provider #	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N253	Missing/incomplete/invalid attending provider primary identifier.	CO
H11	Included in Primary Procedure This procedure has been included in the primary procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H12	Primary Procedure Must be Billed The procedure was denied because it requires an accompanying procedure	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.	CO
H13	Procedure Code Not Valid for DOS The submitted procedure code is no longer valid. Please resubmit	181	Procedure code was invalid on the date of service.	N517	Resubmit a new claim with the requested information.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H14	Procedure Code Incorrect For Gender The gender of the patient does not correlate with the submitted	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
H15	Diagnosis Invalid For Gender This was denied because the diagnosis is not appropriate based on the	10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO
H16	Procedure Code Inapp. for Age The age of the patient does not correlate with the submitted procedure	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
H17	NCCI Denial- Mutually Exclusive This health service code was denied as mutually exclusive of another	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
H18	NCCI Denial-Comprehensive/Component This health service code was denied as a component of a comprehensive	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H19	DX Doesn't Support Procedure Code This procedure code does not match or correlate with the submitted	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
H20	Exceeds Clinical Guidelines Based upon clinical guidelines for this procedure code, the frequency	150	Payer deems the information submitted does not support this level of service.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
H21	Doesn't Meet Observation Criteria Observation care code requires minimum of 8 hours.	150	Payer deems the information submitted does not support this level of service.	N/A	N/A: No Additional Specification Needed	CO
H22	Included in Radiation TX Mgt Svc. These services are included in the weekly radiation treatment	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H23	Reduction for Ionic Contrast Media When non-ionic contrast media is submitted a reduction will be taken	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
H24	Included in Global Fee This code is included in the global fee for another procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H25	Recoded to Complete Procedure Code Based on the other procedures billed for this service date, this code	181	Procedure code was invalid on the date of service.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H26	Multiple Endoscopy Review Multiple endoscopy, modifier 51 has been removed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO
H27	Modifier Adjustment The recommended percentage for this procedure has been adjusted based	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H28	Multiple Procedure Review This code is subjected to a multiple procedure reduction when more	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
H29	Only 1 Service Allowed per Treatment The allowed course of treatment for this procedure code has been	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	M86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	CO
H30	Units Adjusted Exceeds Allowed Amt The units for the billed procedure code have been adjusted to reflect	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N/A	N/A: No Additional Specification Needed	CO
H31	Procedure Bilateral in Nature This procedure was adjusted because the service is bilateral in nature	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO
H32	Invalid Diagnosis Code The diagnosis code listed on the claim is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
H33	Pymt Includes Svcs for Pre/Intra Op Each provider is reimbursed according to the portion of surgical	B20	Procedure/service was partially or fully furnished by another provider.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H34	Code is Incident to Service This was furnished as an integral, although incidental part of the Drs	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H35	submit to Doral Dental Submit Services to Doral Dentel - iHT Specific	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H39	Duplicate Condition 1 Duplicate Logic Condition 1 - Everything the same except Submitted	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H40	Duplicate Condition 2 Duplicate Logic Condition 2 - Everything the same except Allowed	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H41	Duplicate Condition 3 Duplicate Logic Condition 3 - Everything the same except co-pay.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H42	Duplicate Condition 4 Duplicate Logic Condition 3 - Everything the same.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H43	Duplicate Submission This claim has been previously submitted.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H44	Duplicate of New/Deleted Proc Code. During the grace period for a new or deleted procedure code only	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M84	Medical code sets used must be the codes in effect at the time of service.	CO
H46	Deny due to Interaction with other drug Service denied because potential interactions with another drug	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO
H50	Prev Proc/Paid to Same/Diff Provider Same procedure has been paid or processed to the same or different	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	CO
H51	Not a Covered Procedure Certain procedures are not covered as deemed by the 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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H52	Same/Similar Procedure Done Recently Patient history indicates that this service/procedure code has been	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
H54	Technical Service Not Payable for POS This procedure is billed as a technical component and is not payable	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
H55	Payable Only W/ Active Intervention Procedure requires active intervention and is not payable when	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N674	Not covered unless a pre-requisite procedure/service has been provided.	CO
H56	CPT Seperate Procedure Policy This procedure/service is not paid separately	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H57	Modifier removed on Termed Proc Code Modifier removed. Terminated procedure can not be billed bilaterally	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
H58	Mutually Exclusive of Another Proc This code should not be reported since a similar procedure was	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO
H62	Co-Surgeons Not Allowed Procedure denied. The procedure code submitted does not necessitate	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N450	Covered only when performed by the primary treating physician or the designee.	CO
H63	Procedure Recoded Based on Age The procedure code has been recoded based on the age of the patient.	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H64	Diagnosis Invalid for Age The age of the patient does not correlate with the submitted	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO
H65	Modifiers Re-Ordered The modifiers on the claim line were reordered based on the	182	Procedure modifier was invalid on the date of service.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H66	Principle Diagnosis incorrectly utilized Missing/Incomplete/Invalid Principle Diagnosis	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
H70	Included in Primary Procedure This service code was denied because it is included in the CPT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
H71	Procedure Code Inappropriately Coded This service code was denied because it is inappropriately coded	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N657	This should be billed with the appropriate code for these services.	CO
H72	Deny Item doesn't meet definition of DME Item denied because it is an item of convenience, item is not medical	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO
H73	Rental Cap Exceeded The billed equipment was denied because the maximum number	108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N370	Billing exceeds the rental months covered/approved by the payer.	CO
H74	Not Covered for Diagnosis Indicated This health service code was denied as it is not a covered service	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
H75	Recoded to the least Costly Alternative The Procedure has been recoded to a procedure code	181	Procedure code was invalid on the date of service.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H76	Mod Inappropriate/Req/Inval for Service Modifier Inappropriate/Required/Invalid for Service	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H77	Modifier Inappropriate for Procedure This procedure was denied because it was billed with a modifier that	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
H78	Age Doesn't Support DX Billed The age of the patient does not correlate with the submitted diagnosis	9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.	CO
H80	Lab compnt price exceeds lab panel price Price of Lab Panel components exceed lab panel price	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N70	Consolidated billing and payment applies.	CO
H81	Secondary Diagnosis Missing Or Invalid This health service code was denied because a required secondary	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
H82	Modifier Inappropriately Coded The modifier for this service has been changed to reflect appropriate	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
H83	Procedure Recoded To Delivery Only Servi Code was changed to reflect that the provider did not provide the	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H84	HCPCS Code Not Appropriate According to CMS guidelines, the billed HCPCS code has been	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H90	Recoded Procedure Code The billed procedure was recoded to a more appropriate procedure code	181	Procedure code was invalid on the date of service.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H91	Procedure Code Inappropriately Coded This code has been changed or denied to reflect a more appropriate	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M81	You are required to code to the highest level of specificity.	CO
H92	Inappropriate Place of Service The Place of Service indicated on the claim is not appropriate for	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
H93	E&M Code level Re-coded The level of the Evaluation and Management visit has been recoded	150	Payer deems the information submitted does not support this level of service.	N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	CO
H94	Surg & Asst Surg Can't Be The Same This code can not be paid as a Surgical assist when the same provider	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO
H95	Only 1 E&M Code Allowed Per Day This E&M service was denied because only 1 E&M service is allowed for	B14	Only one visit or consultation per physician per day is covered.	M86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	CO
H96	More Than 1 Asst Surgeon Not Allowed Only one assistant surgeon is allowed for the procedure submitted.	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO
H97	Procedure Code Inappropriately Coded This procedure code has been denied based on the circumstances in	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M81	You are required to code to the highest level of specificity.	CO
H98	Packaged Incidental Service Payment is included in the allowance for another service/procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
H99	Not Covered for Provider Specialty Certain procedures are not covered for specific specialties as deemed	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO
HA1	Resubmit with supporting documentation Resubmit with supporting documentation	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M127	Missing patient medical record for this service.	CO
HA2	Payment for this service/item is bundled Payment for this service/item is bundled	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
HA3	Bill to DME MAC Bill to DME MAC	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N/A	N/A: No Additional Specification Needed	CO
HAC	Medicaid Policy Denial Medicaid Policy Denial	242	Services not provided by network/primary care providers.	N767	The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.	CO
HAO	HMS Allowable Override HMS Allowable Override	94	Processed in Excess of charges.	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HAZ	Include in monthly rental fee This health service code was denied because it is considered to be	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
HB1	Bilateral Surgery 150% Rule Applies Unilateral Procedure Code. The 150% Payment Adjustment Rule applies	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO
HB2	Bilateral Surgery 100% rule applies This is a Bilateral Procedure Code and payment for the code is already	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HB3	Bilateral - Modifier Incorrect This is a Bilateral Code. Modifiers LT, RT, 50 or qty 2 are not	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HB4	Missing CC/MCC Diagnosis The Provider's billed DRG indicates a complication/comorbidity that	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
HB5	DRG Doesn't Match The billed DRG does not match the Grouper DRG	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N208	Missing/incomplete/invalid DRG code.	CO
HB6	Invalid Discharge Status Invalid Discharge Status	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N50	Missing/incomplete/invalid discharge information.	CO
HB7	LCD - Procedure vs Diagnosis Billed DIagnosis does not support Medical Necessity - refer to LCD	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HB8	LCD - Procedure vs Diagnosis Billed DIagnosis does not support Medical Necessity - refer to LCD	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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.	CO
HB9	Non -Covered Revenue Code Not a covered revenue codeHealthcare	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
HC1	Administration Codes exceed Vaccine Code Administration Codes exceed Vaccine Code	94	Processed in Excess of charges.	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HC2	Qty Exceeds Max - Unspecified(Roll/Deny) Per Plan guidelines, the Quantity Maximum for Specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC3	Qty Exceeds Max- Unspecified Per Plan Guidelines, the quantity maximum for specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC4	Qty Exceeds Max -Specified Fiscal Per Plan Guidelines, the quantity maximum for specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC5	Qty Exceeds Max Specified Calendar(Deny) Per Plan Guidelines, the quantity maximum for specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC6	Qty Exceeds Max - Specified Rolling(Deny Per Plan Guidelines, the quantity maximum for specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC7	Qty Exceeds Max-Time Span Rule/One Day Per Plan Guidelines, the quantity maximum for specified time period	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HC8	Quantity Payor Specific Quantity of service exceeds the payor specified limit	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HC9	Quantity Invalid Quantity of service exceeds the payor specified limit	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
HDR	High Dollar Review Team	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO
HH1	Resubmit to Care centrix Resubmit to Care centrix	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
HM0	HMS Overturn Appeals Process Review Appeal Overturn	216	Based on the findings of a review organization	MA91	Alert: This determination is the result of the appeal you filed.	CO
HM1	Date of service is Later Than Date Recd Date Of Service Is Later Than Date Received Or Future Date Of Service.	110	Billing date predates service date.	N/A	N/A: No Additional Specification Needed	CO
HM2	Not Appr. To Bill Ext DX W/O another DX Not Appropriate To Bill An External Cause Diagnosis W/O another	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HM3	Not Appr to Bill Ext DX code in 1st pos. Not Appr to Bill External Cause DX in the First ICD Position	167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
HM4	E&M svs. Btwn Global Pre and Post Op Per E&M svs. Btwn Global Pre and Post Op Period	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO
HM5	Surgical Proc Rptd after E&M Payment Surgical Proc Rptd after pymt of E&M. E&M Svs are Between The Global	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
HM6	Surgical Proc Rptd after E&M Payment Surg. Proc Rptd after pymt of E&M. Svs. E&M Svs is between the Global.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
HM7	Procedure is Mutually Exclusive Procedure is Mutually Ex. Not Poss.For both Proc.to Occur at same time	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HM8	Proc. is Mut. Excl, Non Pay Cd pd prior Mutually Excl.Proc is listed on Prior claims run For the same DOS.	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HM9	Based on NCCI Two Proc are Mutual Excl. Based on NCCI Two Proc. Are Mutually Excl. If it is not Possible to	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HMA	Hosp.Outpt Procedure is Mutually Excl. Hosp Outpt Proc.is Mutally Excl. Two Proc are consid. Mut Exclusive	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HMB	Hosp.Outpt Proc.is Mut.Excl.On Prior Clm Hosp.Outpt Proc.is Mut.Excl to Prior Clm submisson on same DOS	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HMC	Hosp.Outpt.Based on NCCI Proc Mut Excl Hosp.Outpt.Bsd on NCCI Proc Mut Excl.Non payable code was Pd	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HMD	Gender of Patient Not Consistent w/Code The Gender Of The Patient Is Not Consistent With Service Code Billed.	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HME	Phys.Ther Svs not payble in Hosp.Setting Physical Therapy Service Is Not Payable In A Hospital Inpatient	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
HMF	This Procedure is an Add On Code This Procedure is an Add on Code and must be billed with the	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N122	Add-on code cannot be billed by itself.	CO
HMG	This Procedure is an Add On Code This Procedure is an Add On Code and must be billed with the	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N122	Add-on code cannot be billed by itself.	CO
HMH	Anesthesiologist must use CPT Codes Anesthesiologist must use CPT Codes (00100-01999) plus State Specified	95	Plan procedures not followed.	N95	This provider type/provider specialty may not bill this service.	CO
HMI	Anethesia Provided by a Non-Anes Anethesia Provided by a Non-Anesthesiologist (Check for Addtional	194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	N/A	N/A: No Additional Specification Needed	CO
HMJ	Procedure should be bundled Procedure should be bundled in an All Inclusive Procedure	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
HMK	All Components of Lab Panel Billed All of the Components of a Lab Panel Have been billed. Only the Lab	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HML	Bilateral Proc Code pymt based both side Bilat Proc Code and pymt based on both sides. Pay lessor of 100% of	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO
HMM	This is a Bilateral Code This is a Bilat code. Modifier LT, RT, 50 or Qty 2 not applicable. Th	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HMN	Co-Surgeon not allowed for procedure Co-Surgeons are not allowed for this procedure	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO
HMO	Co- Surgeon - Different Specialties Co- Surgeons are only allowed if the providers are in different	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO
HMP	Spec Billed Serv Code combo not payable Based on NCCI, the Specific billed service code combo is not payable.	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.	N/A	N/A: No Additional Specification Needed	CO
HMQ	Hosp O/P Specific Billed Serv Code Combo Hospital Outpatient Based on NCCI. The specific billed service code is	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.	N/A	N/A: No Additional Specification Needed	CO
HMR	Procedure code is missing or invalid The Procedure code is missing or invalid at Time of Service	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HMS	This Revenue code is invalid This Revenue code is invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
HMT	Rev Code requires a Procedure Code This Revenue Code Requires a Procedure Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO
HMU	Mod QW required Per CLIA Requirements a modifier QW is required for this procedure	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HMV	Rev Code cannot be billed w othr Rev Cod Revenue Code cannot be billed with other billed Revenue Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO
HMW	Verfiy Benefits and Elig Verfiy Benefits and Eligibility for Services Provided in a State	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HMX	Code Combo not payable Based on NCCI the specific billed service code combination is not	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.	N/A	N/A: No Additional Specification Needed	CO
HMY	Duplicate Procedure on Same Day Duplicate Procedure on Same Day	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HMZ	Only one visit allowed per day Only one visit allowed per day	B14	Only one visit or consultation per physician per day is covered.	N/A	N/A: No Additional Specification Needed	CO
HOS	Hospice Member - Submit to Medicare Submit Charges to Medicare	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
HS0	More than one Interp and Reading perfrmd More than one interpretation and reading being performed for the same	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
HS1	Diagnosis Codes missing or inval on DOS All Diagnosis codes are invalid on the DOS or requires a	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
HS2	Member not Eligible at Time of Service Member was not Eligible at Time of Service	200	Expenses incurred during lapse in coverage	N650		CO
HS3	3 day window OP serv included w IP stay 3 day window (72 hour) outpatient services should be included in the I	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
HS4	Ambulance Service while Inpatient Ambulance Services were provided while the member was an IP	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M2	Not paid separately when the patient is an inpatient.	CO
HS5	Included in E&M Procedure is included in E&M Code	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HS6	Incidental Phys Service Item or Service is incidental to the Physician's Service	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N390	This service/report cannot be billed separately.	CO
HS7	Denied in Hospital In/Out Service is not payable in a Hospital Inpatient or Outpatient setting	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HS8	Required Modifier Missing This service was billed without the plan required modifier	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HS9	Mod 26/TC Not allowed for Service Modifiers 26 or TC are not allowed for Professional or Technical	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HSA	Mod TC not allowed for this Service Code Modifier TC is not allowed for this Service Code	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HSB	MUE for Physicians Medicallly Unlikely Edits for Physicians	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N/A	N/A: No Additional Specification Needed	CO
HSC	MUE for DME Medically Unlikely Edits for DME	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N/A	N/A: No Additional Specification Needed	CO
HSD	MUE For Hospitals Medically Unlikely Edits for Hospitals	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N/A	N/A: No Additional Specification Needed	CO
HSE	Non covered member SIU has never received eligibility for this member	31	Patient cannot be identified as our insured.	N/A	N/A: No Additional Specification Needed	CO
HSF	Non Covered member/plan Member benefits are not payable through this plan	31	Patient cannot be identified as our insured.	N/A	N/A: No Additional Specification Needed	CO
HSG	Not a Covered Service Not a Covered 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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	CO
HSH	Carve out Benefit Services are Carved out for payment by another entity	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HSI	Payment Hold - Rec'd Date Payment hold based on Received Date	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HSJ	Payment Hold - DOS Payment hold based on Date of Service	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HSK	Partial Payment Hold - Rec'd Date Partial Payment Hold based on Received Date	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HSL	Partial Payment Hold - DOS Partial Payment Hold Based on Date of Service	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO
HSM	POS - Non Facility POS for this Procedure is invalid or not normally performed in this	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
HSN	POS Plan Specific/Service Code Per Plan requirements specific place of service(s) are required when	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
HSO	POS Plan Specific Service Code Per Plan requirements service code cannot be billed with the POS	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.	CO
HSP	Code combination - CC2 Retro Based on NCCI the specific billed service code combo is not payable.	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	CO
HSQ	Code Combination Hosp CCR Retro Hospital OP NCCI the specific billed service code combo is not payable	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	CO
HSR	State Code Combination Per State Regulations the specific Billed Service code Combination is	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	CO
HSS	State Code Combination - Hospital Hospital Outpatient - Per State Regulations the specfic billed service	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	CO
HST	Carve out Services - State Specific Services are carved out for payment by another entity -	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
HSU	Time of Filing - 1 year Date of Procedure in Excess of 1 year prior to receipt of claim	29	The time limit for filing has expired.	N/A	N/A: No Additional Specification Needed	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HSV	Team Surgeons not allowed Team Surgeons not allowed for this procedure	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO
HSW	Pre Admit Service included in Hospitaliz 3 Day window OP Serv s/b included in IP Stay. Non Payable Code pd	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
HSX	Modifier not Applicable Per Plan Requirements, the service code and modifier cannot be billed	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HT0	Established /New Patient An Established visit should be billed instead of New Patient	B16	'New Patient' qualifications were not met.	N/A	N/A: No Additional Specification Needed	CO
HT1	Multiple Proc Reduction - Imaging Multiple Procedure Payment Reduction on the Technical Component	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HT2	Multiple Paymnt Reduction Imaging Multiple Procedure Payment Reduction on the Technical Component	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HT3	Place of Service Facility Place of Service for this procedure is invalid or not normally	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
HT4	Provider Type/Service not allowed The Specialty of the provider performing this service is not allowed	170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO
HT5	Provider Type Billed Services The Provider's Specialty Type has a limitation of service codes	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO
HT6	Provider Type/Service Specialized This Service Code can only be billed by Certain Provider Types.	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
HT7	Admin Code without Vaccine Code Administration Service Billed with Modifier U2 or U3 without	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
HT8	NCCI Column 1 denied,Column II paid prev NCCI Column I and Column II codes billed out of sequence for same date	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M80		CO
HU1	Resubmit to HearUSA Resubmit to HearUSA	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
N01	Subset Procedure Disallow This procedure is considered incidental to or a part of the primary	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N02	Redundant Procedure Disallow This procedure is reconsidered redundant to the primary procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N03	Secondary Procedure Disallow This procedure is considered secondary to the primary procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N04	Follow-Up Service Disallow This service is considered a part of the original surgical procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
N05	Same Day Procedure Disallow This service is not covered when performed on the same day as	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO
N06	Assistant Surgeon Disallow This procedure does not normally require the services of an assistant	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO
N09	Cosmetic Procedure Disallow This procedure is normally performed for cosmetic purposes	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
N10	Investigation Disallow This procedure is considered experimental in nature and not a covered	55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	CO
N11	Outdated Procedure Disallow This procedure is no longer considered clinically effective	56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N13	Invalid Procedure Disallow This Procedure Code Was Deleted or Not Valid on Date of Service	181	Procedure code was invalid on the date of service.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
N14	Invalid Gender for Procedure Member's Sex Not Valid for Procedure Code	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N15	Age exceeds normal range for procedure This service is not normally performed for members in this age range	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
N16	Age exceeds extreme range for procedur This service is not normally performed for members in this age range	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
N17	Invalid place of service for procedure This service is not covered when performed in this setting	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N19	Invalid Diagnosis for Procedure This service is not covered when performed for the reported diagnosis	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N25	Charges were combined into primary pr The charges for this service have been combined into the primary	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N26	Pretreatment Procedure Disallow Pretreatment Procedure Disallow	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	OA
N27	Invalid Modifier Disallow Invalid Modifier Disallow	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.	CO
N28	Preop proc. Occurred 1day of surg proc. Current preoperative procedure occurred within 1day of an associated	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO
N29	Clinical Daily Maximum Exceeded Clinical Daily Maximum Exceeded	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
N30	Lifetime Maximum Exceeded Lifetime Maximum Exceeded	35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	CO
N50	Current Procedure Rebundle Current Procedure Rebundle	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
N51	History Procedure Rebundle History Procedure Rebundle	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
N52	Duplicate Uni or Bilateral Procedure Duplicate Uni or Bilateral Procedure	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
N53	Dup History Uni or Bilateral Proc Dup History Uni or Bilateral Procedure	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
N54	Daily or Lifetime Max Occurrence Daily or Lifetime Max Occurrence	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	CO
N55	History Daily/Lifetime Max Occurrence History Daily/Lifetime Max Occurrence	35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	CO
N56	Duplicate Procedure Submitted Duplicate Procedure Submitted	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
N57	History Dup Procedure Submitted History Dup Procedure Submitted	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
N58	History Mutually Exclusive Procedure History Mutually Exclusive Procedure	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N59	History Incidental Procedure History Incidental Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N60	Assistant Surgeon Sometimes Required Assistant Surgeon Sometimes Required	54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
N61	Age Conflict Replaced Procedure Age Conflict Replaced Procedure	6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
N62	Gender Conflict Replaced Procedure Gender Conflict Replaced Procedure	7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO
N63	History Proc Added Line Rebundle History Procedure Added Line Rebundle	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
N64	History PreOp Conflict Within 1 Day History PreOp Conflict Within 1 Day	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO
N65	HisT PostOP Conflict within 90 Days History PostOP Conflict within 90 Days	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO
N66	History Medical Visit Conflict History Medical Visit Conflict	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO
N67	New Pt Visit Conflict Procedure New Pt Visit Conflict Procedure	B16	'New Patient' qualifications were not met.	N/A	N/A: No Additional Specification Needed	CO
N68	Intensity of Service Conflict Intensity of Service Conflict	150	Payer deems the information submitted does not support this level of service.	N640	Exceeds number/frequency approved/allowed within time period.	CO
N69	Dupl Component Billing Conflict Cur Duplicate Component Billing Conflict Current or History	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	OA
N70	Diagnoses do not support this procedure Submitted diagnoses do not support this procedure	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
N71	Multiple Component Billing Conflict Multiple Component Billing Conflict	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO
N72	Units of service exceed MUE limit Units of service exceed Medically Unlikely Edit	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO

EOB Code	EOB Description	Claim Adjustment Reason Code	CARC Definition	Remittance Remark Code	RARC Definition	Provider Adjustment Reason Code
N73	Third Party Liability Potential Third Party Liability Potential	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N193	Alert: Specific federal/state/local program may cover this service through another payer.	OA
N76	Invalid Proc Modifier Combination Invalid Procedure Modifier Combination	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 03/01/2020: The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.	CO
N77	Invalid Modifier Invalid Modifier	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.	CO
N78	Invalid Diagnosis Code Invalid Diagnosis Code	146	Diagnosis was invalid for the date(s) of service reported.	N657	This should be billed with the appropriate code for these services.	CO
N79	Units Expansion Failed Units Expansion Failed	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.	CO
N81	Diagnoses may not support this procedure Submitted diagnoses may not support this procedure	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
N82	Diagnoses for this procedure monitored Submitted diagnoses for this procedure monitored	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO
N91	CCI Incidental Procedure CCI Incidental Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N92	History CCI Incidental Procedure History CCI Incidental Procedure	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.	CO
N93	CCI Mutually Exclusive Procedure CCI Mutually Exclusive Procedure	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO
N94	History CCI Mutually Exclusive Procedure History CCI Mutually Exclusive Procedure	231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A: No Additional Specification Needed	CO