Common Adjustment Reasons and Remark Codes

CARC & RARC Summary Explanation

These reports include the HIPAA reason codes and their translation to MIHMS' more detailed internal processing codes.

This document is used as a crosswalk between the edit rules that can be viewed on a claim in the Health PAS online portal and the mapped codes on that must follow the HIPAA EDI standard codes for a Remittance advice or 835.

CARC Code	Claim Adjustment Reason Code Description	MIHMS Rule Description	Edit Rule Status	Additional Details
HIPAA Code	Claim Adjustment Reason Codes, often referred to as CARCs, are standard HIPAA compliant adjustment codes. They communicate why a claim or service line was paid differently than it was billed.	MIHMS Edit Rules are mapped to the HIPAA compliant definitions and may in some instances be more descriptive. More than one (1) MIHMS Rule may be mapped to a single HIPAA compliant code.	Indicates what happens when the specific MIHMS Rule has been triggered. Statuses are current as of June 7, 2012 and are subject to change.	Guidance on changes and/or reviews that might allow the claim to be processed for payment.
			-Warn: An alert for provider review. will not prevent a claim from being paid and will not delay processing.	
RARC	**Remittance Advice Remark Code Description**			
HIPAA Code	Remittance Advice Remark Codes, often referred to as RARCs, are standard HIPAA codes. They are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code Legend.		-Deny: means that any claim triggering this edit will automatically deny.	
			-Pend: means that a claim must be reviewed by a claims resolution analyst to determine if the MIHMS Edit Rule has been satisfied. If it has, the resolution analyst will approve the claim for payment. If not met, the claim will be denied. There are no definite timelines for the pend review process, however, claims are reviewed based on first-in, first-out basis.	

Notes:

To print the entire 24 page document: Click the Office button within Microsoft Excel in the upper left hand corner, select Print and Print Again. Select "Entire Workbook" in the Print What" grouping and click OK.

A complete list of the HIPAA compliant CARCs are available at: http://www.wpc-edi.com/content/view/695/1

A complete list of the HIPAA compliant RARCs are available at: http://www.wpc-edi.com/content/view/739/1

Common Adjustment Reasons and Remark Codes

Claims Adjustment Reason Code Description to MIHMS Rule Description Crosswalk

This report is a summary of the HIPAA Reason Codes that appear on your MIHMS Remittance Advice crosswalked to the MIHMS Rule descriptions.

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	169-Claim and contract term modifiers do NOT match	DENY	
		245-Multiple surgeries - claim submitted missing modifier 51	WARN	
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	179-Location specific term does NOT match claim	DENY	
		185-Location-specific benefit does NOT match claim	DENY	
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	155-Benefit has age restriction	DENY	
		168-Member does not meet age criteria for term	DENY	
		401-Age is invalid for Medical Policy	DENY	
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	400-Gender is invalid for Medical Policy	DENY	
		911-Invalid For Male	DENY	
		912-Invalid For Female	DENY	
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	157-Contract Term requires Specialty Code not found on provider	WARN	Provider requires a specialty code
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	330-Invalid diagnosis code for benefit	DENY	
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	606-Prior Authorization number not found	PEND	Authorization number must match exactly
		607-Prior Authorization not for same member	DENY	
		608-Prior authorization not for same provider	DENY	
		609-Prior Authorization dates do not match claim	DENY	Authorization number invalid for DOS
		610-Prior Authorization Services do not match claim	PEND	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		618-Provider's group does not match authorized group	PEND	
		622-Place of Service does not match authorized	PEND	Check authorization for place of service specifics
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	162-Contract term requires documentation	PEND	Documentation or claims history review by claims resolution staff
		163-Benefit requires documentation	PEND	Documentation or claims history review by claims resolution staff
		164-Contract requires document review	PEND	Documentation or claims history review by claims resolution staff
		175-Bill type on claim does not match contract term	PEND	No contract term found for service
		224-Benefit requires manual review	PEND	Documentation or claims history review by claims resolution staff
		225-Contract term requires manual review	PEND	Documentation or claims history review by claims resolution staff
		238-Invalid Medicare Action Code	DENY	
		289-Invalid occurrence code on DOS	DENY	
		290-Invalid occurrence span code on DOS	DENY	
		291-Invalid condition code on DOS	DENY	
		292-Invalid value code on DOS	DENY	
		304-Invalid bill type	DENY	
		376-Contract term restriction group validation failed	DENY	Review place of service or provider type restriction to perform the service
		505-Invalid revenue code	DENY	
		523-Invalid ICD-9 diagnosis code	DENY	
		635-Invalid claim form type	DENY	Claim form review by claims resolution staff
		916-Claim does not have any service lines	DENY	
		6010-Invalid Service Location Selection	PEND	
18	Duplicate claim/service.	502-Duplicate Line on Same Claim	PEND	
		522-Duplicate Claim Line (Same Provider/Member/DOS/CPT(Rev))	WARN	
		532-Duplicate Mem/DOS/Service code/Pay To/Rendering	DENY	
		706-CDT already billed on this date by same provider	DENY	
		707-CDT already billed on this date	PEND	
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	366-Workers Compensation Claim	WARN	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
20	This injury/illness is covered by the liability carrier.	263-Auto Accident indicated on claim - Pursue and Pay	WARN	
22	This care may be covered by another payer per coordination of benefits.	216-No COB entered with a secondary enrollment	PEND	Resubmit with primary EOB
		252-Pend claim if COB is 0 on secondary enrollment claim	PEND	Resubmit with primary EOB
		374-Medicare Excluded Service - Other Insurance Dollars on Claim	WARN	
		378-No COB amount on claim	PEND	EOB needed to review
		384-Potential other accident	WARN	Might be covered by another payer
		6002-Medicare Crossover QMB Processing Rules Applies	DENY	
		6003-No COB Amount on TPL Dental	PEND	
		6025-No TPL Dollars Submitted on Medicare Claim	PEND	
23	The impact of prior payer(s) adjudication including payments	253-Internal enrollment and COB amounts entered	WARN	Member might have other coverage
29	The time limit for filing has expired.	311-Claim Submission Window Exceeded [All Claims, header date]	WARN	
		541-Claim Line Submission Window Exceeded	PEND	
		543-Inpatient Claim Submission Window Exceeded [header to date]	PEND	
38	Services not provided or authorized by designated (network/primary care) providers.	286-No PCP on DOS	WARN	
		5011-Provider does not match lock -in provider - Full lock-in	PEND	
		5012-Provider does not match lock -in provider - Partial lock -in	PEND	
39	Services denied at the time authorization/pre-certification was requested.	604-Prior Authorization is denied	DENY	
		616-Authorization Line Denied	DENY	
		624-Authorization line manually denied	DENY	
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	176-Emergency requirements on claim do NOT match contract term	PEND	
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	134-Claim payment amt exceeds max allowed for mass adjudication	PEND	
		135-Claim payment amount exceeds the maximum allowed	PEND	
		190-Authorization contract overriding contracted provider	WARN	Claim priced by an authorization
		542-Claim Line Submission Window Overlap	PEND	
		5030-FQHC/RHC/Hospital subsequent lines denied	WARN	
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	221-Assistant surgeon not allowed	DENY	
		222-Co-Surgeon not allowed	DENY	
		223-Team surgeon not allowed	DENY	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	230-Multiple surgeries detected	WARN	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	219-Provider overlap of global days period	PEND	
		382-Global payment allocated	WARN	Notification of a global payment
		524-CPT codes billed include bundled and unbundled CPTs	DENY	{Billed CPT} Is included as bundled/unbundled for {CPT Bundled Code}
107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	918-Connect requires claim review	PEND	
119	Benefit maximum for this time period or occurrence has been reached.	116-Annual Benefit Amount Exceeded	DENY	
		123-Individual Lifetime Visits Exceeded	DENY	
		206-Benefit Visit Limit Exceeded	DENY	
		207-Benefit Dollar Limit Exceeded	DENY	
		322-Covered days exceeds maximum for hospital	DENY	
		402-Maximum units exceeded for Medical Policy	PEND	
125	Submission/billing error(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.)	107-Negative charge on claim line	PEND	
		204-Invalid accommodation days	PEND	
		214-Bill Type does not match benefit	PEND	
		301-Invalid or missing admission date	DENY	Missing/incomplete/invalid admission date
		303-Claim total mismatch	DENY	Claim lines billed amount doesn't equal what is on the claim header
		306-Discharge status is required for inpatient and SNF claims	DENY	
		308-Invalid Admit Hour (0 -- 23)	DENY	
		309-Invalid discharge hour (0 -- 23)	DENY	
		312-Invalid coinsurance days for 11x bill type	WARN	
		313-Covered days do not match accommodation rev code days	WARN	
		316-Admit type does not match admit source	WARN	
		318-Invalid coinsurance days for 21x bill type	WARN	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		319-Coinsurance days exceeds covered days	WARN	Evaluate coinsurance days and covered days billed
		328-Admission source required	PEND	
		329-Invalid patient status for bill type	PEND	
		507-Revenue code requires HCPCS	DENY	
		511-Invalid from DOS	DENY	Missing/incomplete/invalid “from” date(s) of service
		512-Invalid thru DOS	DENY	Missing/incomplete/invalid “to” date(s) of service
		518-Admit type required for 11x bill type	DENY	
		703-Invalid tooth number	DENY	Review validity of number by claims resolution staff
		704-Invalid tooth surface for tooth	DENY	
		709-CDT requires tooth surface min/max count	DENY	
		712-Dental area/Tooth mismatch	DENY	
		5031-Claim must be billed for the entire month	DENY	
133	The disposition of this claim/service is pending further review.	105-Provider on pay hold	WARN	
		111-Provider Watch	PEND	Provider watch flag has been set for review
		613-Claim Requires Manual Processing	PEND	
		913-Manual Pend of Claim	PEND	
141	Claim spans eligible and ineligible periods of coverage.	218-Member lost eligibility during date span	WARN	
143	Portion of payment deferred.	6027-Fiscal Pend	PEND	
146	Diagnosis was invalid for the date(s) of service reported.	305-Primary ICD-9 diagnostic code is required	DENY	
		525-ICD-9 diagnosis code is not valid on DOS	DENY	
147	Provider contracted/negotiated rate expired or not on file.	101-No active provider contract	PEND	
		102-Provider not active for Plan on DOS	DENY	
		334-APC/OPPS claim pricing failure	WARN	
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	6018-Medically Unlikely	DENY	
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	173-Diagnosis on claim does NOT match terms valid range	DENY	

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CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	165-Dental Areas on Claim Line and Benefit do not match	DENY	
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	152-Provider type does not match type required by benefit	DENY	Provider does not match required provider type
		156-Provider type does NOT match type required by contract term	WARN	
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	154-Benefit requires specialty code not found on provider	DENY	Provider requires a specialty code
177	Patient has not met the required eligibility requirements.	201-No enrollment segment	PEND	
		210-Member NOT enrolled on DOS	WARN	
		217Member has an active restriction on enrollment	PEND	
178	Patient has not met the required spend down requirements.	6017-Spenddown	PEND	
181	Procedure code was invalid on the date of service.	158-Invalid Service Code on DOS	DENY	
		504-Invalid CPT/HCPCS code	DENY	
		521-Procedure code not found or invalid for date of service	DENY	
		702-Replace obsolete code	DENY	
182	Procedure modifier was invalid on the date of service.	503-Invalid CPT Modifier	DENY	
		508-Invalid Modifier Code on Date of Service	DENY	
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	108-Uncredentialed provider	WARN	
		150-No contract term found for service	DENY	
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	6024-Crossover Hospital Pricing Rules Applied	WARN	
197	Precertification/authorization/notification absent.	205-Benefit requires authorization	PEND	
		236-Benefit requires either authorization or referral document	WARN	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		367-Contract term requires authorization	PEND	
		601-Prior Authorization Is Closed	DENY	
		602-Prior Authorization Is Awaiting Medical Review	PEND	
		603-Prior Authorization Is Pended	PEND	
		625-Authorization Line Manually Pended	PEND	
198	Precertification/authorization exceeded.	611-Prior authorization has no available units	DENY	
		612-Prior authorization has insufficient units remaining	DENY	
		614-No Available Bed Days on Auth	DENY	
199	Revenue code and Procedure code do not match.	515-Invalid HCPCS for Revenue Code	DENY	
		5026-Missing Revenue Code for J -Code	DENY	
200	Expenses incurred during lapse in coverage	6001-Benefit Exhaustion Period Reported	DENY	
204	This service/equipment/drug is not covered under the patient's current benefit plan	149-Benefit does NOT meet date criteria of the claim	DENY	
		172-Term does NOT meet date criteria of the claim	DENY	
		202-No Benefit for Service	PEND	
		203-Benefit is excluded from benefit plan	DENY	
		6019-No Benefit for Crossover Services	PEND	
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	5021-Drug not rebateable	DENY	
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	177-Term is for EPSDT claims only	WARN	Code not found in Maine care fees
		177-Term is for EPSDT claims only	WARN	Code not found in Maine care fees
		258-Emergency Claim does not match Emergency benefit	DENY	Emergency indicator might be missing on claim
		408-Line failed for medical policy rule	DENY	Invalid billing per Maine care policy
		409-Line failed for Medical Policy rule overridden on Cert	WARN	
		915-Claim has been manually denied	DENY	
		919-Contract Price on Service Line has been manually overridden	WARN	Manual pricing done by staff
		920-Contract Price on Service Line Manually Overridden to Zero	WARN	
		921-Claim manually priced with no balance checks or validation	WARN	
		922-Manual Contract price exceeds billed amount on service line	PEND	Manual pricing done by staff
		5022-NDC/JCode is Missing/Invalid	DENY	
		5025-Multiple instances of same J Code not allowed for same DOS	DENY	
		5027-EyeCare Budget Exceeded	DENY	
A8	Ungroupable DRG.	359-Micro-Dyn DRGActive component error	PEND	

Common Adjustment Reasons and Remark Codes

CARC	Claim Adjustment Reason Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		360-DRG is NOT in the selected DRG Group	PEND	
B5	Coverage/program guidelines were not met or were exceeded.	271-Benefit Restriction Group Validation Failed	DENY	
		272-Member does not have coverage code required on benefit	PEND	Member eligibility
		6008-Under Review	PEND	
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	103-Not an approved service for provider	DENY	
		104-Incomplete provider	PEND	
		6007-Under Review	PEND	
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	339-APC claim has lines that have rolled up into other lines	WARN	

Common Adjustment Reasons and Remark Codes

Remittance Advice Remark Code Description to MIHMS Rule Description Crosswalk

This report is a summary of the HIPAA Remark Codes that appear on your MIHMS Remittance Advice crosswalked to the MIHMS Rule descriptions.

RARC	Remittance Advice Remark Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	382-Global payment allocated	WARN	Notification of a global payment
		524-CPT codes billed include bundled and unbundled CPTs	DENY	{Billed CPT} Is included as bundled/unbundled for {CPT Bundled Code}
M20	Missing/incomplete/invalid HCPCS.	507-Revenue code requires HCPCS	DENY	
M44	Missing/incomplete/invalid condition code.	291-Invalid condition code on DOS	DENY	
M45	Missing/incomplete/invalid occurrence code(s).	289-Invalid occurrence code on DOS	DENY	
M46	Missing/incomplete/invalid occurrence span code(s).	290-Invalid occurrence span code on DOS	DENY	
M49	Missing/incomplete/invalid value code(s) or amount(s).	292-Invalid value code on DOS	DENY	
M50	Missing/incomplete/invalid revenue code(s).	505-Invalid revenue code	DENY	
		5026-Missing Revenue Code for J -Code	DENY	
M51	Missing/incomplete/invalid procedure code(s).	504-Invalid CPT/HCPCS code	DENY	
		916-Claim does not have any service lines	DENY	
M52	Missing/incomplete/invalid "from" date(s) of service.	511-Invalid from DOS	DENY	
M53	Missing/incomplete/invalid days or units of service.	204-Invalid accommodation days	DENY	
		313-Covered days do not match accommodation rev code days	WARN	
M54	Missing/incomplete/invalid total charges.	107-Negative charge on claim line	DENY	
		303-Claim Total Mismatch	DENY	Claim lines billed amount doesn't equal what is on the claim header
M59	Missing/incomplete/invalid "to" date(s) of service.	512-Invalid thru DOS	DENY	
M62	Missing/incomplete/invalid treatment authorization code.	604-Prior Authorization is denied	DENY	
		606-Prior Authorization number not found	DENY	
M64	Missing/incomplete/invalid other diagnosis.	523-Invalid ICD-9 diagnosis code	DENY	
		330-Invalid diagnosis code for benefit	PEND	

Common Adjustment Reasons and Remark Codes

RARC	Remittance Advice Remark Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
M76	Missing/incomplete/invalid diagnosis or condition.	305-Primary ICD-9 diagnostic code is required	DENY	
M86	Service denied because payment already made for same/similar procedure within set time frame.	5025-Multiple instances of same J Code not allowed for same DOS	DENY	
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	6028-NDC/JCode is Missing/Invalid	PEND	
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	5028-Missing Detailed Drug Coding	DENY	
M139	Denied services exceed the coverage limit for the demonstration.	5027-EyeCare Budget Exceeded	DENY	
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	216-No COB entered with a secondary enrollment	PEND	Resubmit with primary EOB
		252-Pend claim if COB is 0 on secondary enrollment claim	PEND	Resubmit with primary EOB
		378-No COB amount on claim	PEND	EOB needed to review
		6002-Medicare Crossover QMB Processing Rules Applies	DENY	
		6003-No COB Amount on TPL Dental	PEND	
		6025-No TPL Dollars Submitted on Medicare Claim	PEND	
MA30	Missing/incomplete/invalid type of bill.	175-Bill type on claim does not match contract term	DENY	No contract term found for service
		214-Bill Type does not match benefit	PEND	Invalid bill type-or provider billed incorrect Revenue Code or CPT
		304-Invalid bill type	DENY	
MA32	Missing/incomplete/invalid number of covered days during the billing period.	322-Covered days exceeds maximum for hospital	DENY	
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	312-Invalid co-insurance days for 11x bill type	WARN	
		318-Invalid co-insurance days for 21x bill type	WARN	
		319-Co-insurance days exceeds covered days	WARN	Evaluate co-insurance days and covered days billed
MA40	Missing/incomplete/invalid admission date.	301-Invalid or missing admission date	DENY	
MA41	Missing/incomplete/invalid admission type.	518-Admit type required for 11x bill type	DENY	
MA42	Missing/incomplete/invalid admission source.	316-Admit type does not match admit source	WARN	
		328-Admission source required	WARN	

Common Adjustment Reasons and Remark Codes

RARC	Remittance Advice Remark Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
MA43	Missing/incomplete/invalid patient status.	329-Invalid patient status for bill type	WARN	
MA46	The new information was considered but additional payment will not be issued.	6024-Crossover Hospital Pricing Rules Applied	WARN	
MA106	PIP (Periodic Interim Payment) claim.	6027-Fiscal Pend	PEND	
N19	Procedure code incidental to primary procedure.	219-Provider overlap of global days period	PEND	
N29	Missing documentation/orders/notes/summary/report/chart.	162-Contract term requires documentation	PEND	Documentation or claims history review by claims resolution staff
		163-Benefit requires documentation	PEND	
		164-Contract requires document review	PEND	
N30	Patient ineligible for this service.	155-Benefit has age restriction	DENY	
		168-Member does not meet age criteria for term	DENY	Benefit has age restrictions
		272-Member does not have coverage code required on benefit	PEND	Member eligibility
N34	Incorrect claim form/format for this service.	635-Invalid claim form type	DENY	Review claim form
N35	Program integrity/utilization review decision.	105-Provider on pay hold	WARN	
		111-Provider watch	PEND	Provider watch flag has been set for review
N39	Procedure code is not compatible with tooth number/letter.	703-Invalid tooth number	DENY	Review validity of number
N45	Payment based on authorized amount.	190-Authorization contract overriding contracted provider	WARN	Claim priced by an authorization
N46	Missing/incomplete/invalid admission hour.	308-Invalid admit hour (0 -- 23)	DENY	
N50	Missing/incomplete/invalid discharge information.	306-Discharge status is required for inpatient and SNF claims	DENY	
N54	Claim information is inconsistent with pre-certified/authorized services.	607-Prior Authorization not for same member	DENY	
		610-Prior Authorization services do not match claim	PEND	
		618-Provider's group does not match authorized group	PEND	
		622-Place of Service does not match authorized	WARN	

Common Adjustment Reasons and Remark Codes

RARC	Remittance Advice Remark Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		624-Authorization line manually denied	DENY	
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	5031-Claim must be billed for the entire month	DENY	
N75	Missing/incomplete/invalid tooth surface information.	704-Invalid tooth surface for tooth	DENY	Review validity of number
		709-CDT requires tooth surface min/max count	DENY	Review validity of number
		712-Dental Area/Tooth mismatch	DENY	Review validity of number
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	177-Term is for EPSDT claims only	WARN	Code not found in MaineCare fees
N79	Service billed is not compatible with patient location information.	6010-Invalid Service Location Selection	PEND	
N95	This provider type/provider specialty may not bill this service.	152-Provider type does not match type required by benefit	DENY	
		154-Benefit requires specialty code not found on provider	DENY	
		157-Contract term requires specialty code not found on provider	WARN	
		6007-Under Review	PEND	
N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	253-Internal enrollment and COB amounts entered	WARN	Member might have other coverage
N180	This item or service does not meet the criteria for the category under which it was billed.	176-Emergency requirements on claim do NOT match contract	PEND	
		376-Contract term restriction group validation failed	DENY	Review place of service or provider type restriction to perform the service
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.	258-Emergency claim does not match emergency benefit	DENY	Emergency indicator might be missing on claim
		384-Potential other accident	WARN	Might be covered by another payer
		408-Line failed for medical policy rule	DENY	Invalid billing per MaineCare policy
		409-Line failed for Medical Policy rule overridden on Cert	WARN	
		915-Claim has been manually denied	DENY	
		919-Contract price on service line has been manually overridden	WARN	Manual pricing done by staff

Common Adjustment Reasons and Remark Codes

RARC	Remittance Advice Remark Code Description	MIHMS Rule Description	Rule Status	Additional Details (if applicable)
		920-Contract Price on Service Line Manually Overridden to Zero	WARN	
		921-Claim manually priced with no balance checks or validation	WARN	
		922-Manual contract price exceeds billed amount on service line	PEND	Manual pricing done by staff
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	224-Benefit requires manual review	PEND	Documentation or claims history review by claims resolution staff.
		225-Contract term requires manual review	PEND	
N245	Incomplete/invalid plan information for other insurance	238-Invalid Medicare Action Code	DENY	
N318	Missing/incomplete/invalid discharge or end of care date.	309-Invalid discharge Hour (0 -- 23)	DENY	
N351	Service date outside of the approved treatment plan service dates.	609-Prior Authorization dates do not match claim	DENY	Authorization number invalid for DOS
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	5030-FQHC/RHC/Hospital subsequent lines denied	WARN	
N431	Service is not covered with this procedure.	6018-Medically Unlikely	DENY	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
101	No active provider contract	147	
102	Provider not active for Plan on DOS	147	
103	Not an approved service for provider	B7	
104	Incomplete provider	B7	
105	Provider on Pay hold	133	N35
106	No attending physician ID (outpatient)	125	N253
107	Negative charge on claim line	125	M54
108	Uncredentialed provider	185	
109	Claim amt exceeds maximum allowed during mass adjudication	A1	N22
111	Provider Watch	133	N35
112	Claim amount exceeds the maximum allowed	45	
113	Specialty code required for provider	172	N95
114	Provider does not match required type	170	
116	Annual Benefit Amount Exceeded	119	
117	Lifetime Benefit Max Exceeded	35	
119	Family Benefit Lifetime Max Exceeded	35	
121	Validate External Provider's Program	A1	N220
122	PCP reassignment override days	A1	N220
123	Individual Lifetime Visits Exceeded	119	
124	Family Lifetime Visits Exceeded	119	
125	Partial Units on Lifetime/Individual Visit Limits	119	
126	Partial Units on Lifetime/Family Visit Limits	119	
127	Sponsor Watch	A1	N220
128	Remaining visits less than date span. Units not allocated.	125	M53
130	Program Watch	A1	N220
132	Sum of Individual Coinsured Charges Exceeds Maximum	2	
133	Sum of Family Coinsured Charge Maximum Exceeded	2	
134	Claim payment amt exceeds max allowed for mass adjudication	45	
135	Claim payment amount exceeds the maximum allowed	45	
136	Plan Lifetime Amount Exceeded	2	
137	Plan Family Lifetime Max Exceeded	2	
140	Contract amount is 0	204	
149	Benefit does NOT meet date criteria of the claim	204	
150	No contract term found for service	185	
151	Excluded Contract Term for Service	185	
152	Provider type does not match type required by benefit	170	N95

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
153	PCP is solely responsible for service: pay as capitated	24	
154	Benefit requires Specialty Code not found on Provider	172	N95
155	Benefit has age restriction	6	N30
156	Provider type does NOT match type required by contract term	170	
157	Contract Term requires Specialty Code not found on Provider	8	N95
158	Invalid Service Code on DOS	181	
162	Contract term requires documentation	16	N29
163	Benefit requires documentation	16	N29
164	Contract requires document review	16	N29
165	Dental Areas on Claim Line and Benefit do not match	168	
166	Benefit procedure NOT found in claims history	107	N161
167	Benefit requires prosthesis designation	16	N29
168	Member does NOT meet age criteria for term	6	N30
169	Claim and contract term modifiers do NOT match	4	
170	Claim and contract term type of service do NOT match	A1	N220
171	Term Applies to assigned members only	24	
172	Term does NOT meet date criteria of the claim	204	
173	Diagnosis on claim does NOT match terms valid range	167	
174	Procedure code on claim does NOT match terms valid procedure	204	
175	Bill type on claim does NOT match contract term	16	MA30
176	Emergency requirements on claim do NOT match contract term	40	N180
177	Term is for EPSDT claims only	A1	N78
178	Member is NOT in capitation and contract term is capitated	95	N52
179	Location specific term does NOT match claim	5	
180	No Sponsor Fee for service	133	
181	Stop Loss Applied to Claim	45	
182	No external price found for provider	147	
183	Submission date exceeds policy termination run-off period	27	
184	DOS end date exceeds policy termination date	27	
185	Location-specific benefit does NOT match claim	5	
186	No skilled nursing coverage	204	
187	Benefit requires documents to be reviewed	16	N29
188	Noncontracted provider requires EOMB	16	N4
189	Level of Care Benefit Not Found	204	
190	Authorization contract overriding contracted provider	45	N45
192	Benefit requires contracted (PAR) provider	38	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
194	Restrict Benefit by Date of ONSET	A1	N130
195	Date of Onset is Missing on Claim	16	MA12
196	Benefit requires non-contracted (NONPAR) provider	38	
197	Procedure code on claim NOT valid for benefit	204	
198	Date of Service is after paid through date	125	M59
199	Benefit Rider not valid for member/DOS	B5	N30
200	Benefit Day Limit Exceeded	119	
201	No enrollment segment	177	
202	No Benefit for Service	204	
203	Benefit is excluded from benefit plan	204	
204	Invalid accommodation days	125	M53
205	Benefit requires authorization	197	
206	Benefit Visit Limit Exceeded	119	
207	Benefit Dollar Limit Exceeded	119	
208	Benefit Applies to PCP Only	24	N52
209	Benefit coverage not started	26	
210	Member NOT enrolled on DOS	177	
211	Provider is not part of network required for benefit	38	
214	Bill Type does NOT match Benefit	125	MA30
215	Member's Share of Cost Different than Entered Value	178	
216	No COB entered with a Secondary Enrollment	22	MA04
217	Member has an active restriction on enrollment	177	
218	Member lost eligibility during date span	141	
219	Provider overlap of global days period	97	N19
221	Assistant surgeon not allowed	54	
222	Co-Surgeon not allowed	54	
223	Team surgeon not allowed	54	
224	Benefit Requires Manual Review	16	N225
225	Contract Term Requires Manual Review	16	N225
226	Reimburse Member On Non-Par Contract	A1	N220
230	Multiple surgeries detected	59	
235	Override Reimburse Member option	A1	N220
236	Benefit requires either authorization or referral document	197	
237	COB will be manually distributed on claim lines	A1	N220
238	Invalid Medicare Action Code	16	N245
240	Not all standard reserve days have been used	A1	N220
241	Exceeds number of covered days in a standard benefit period	119	
242	Service days submitted exceed standard reserve days	119	
244	No claim in std benefit period before use of reserve days	107	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
245	Multiple surgeries - claim submitted missing modifier 51	4	
246	Member has Preexisting Condition on DOS for Diagnosis	51	
247	Preexisting Condition May Exist	51	
248	Member policy is Suspended	A1	N220
252	Pend claim if COB is 0 on secondary enrollment claim	22	MA04
253	Internal enrollment and COB amounts entered	23	N155
254	Medicare non-allowed claim submitted hard copy	22	N4
255	Medicare non-allowed claim submitted electronically	A1	N220
256	Invalid Medicare COB Amount	22	
257	Visit units have been traded	A1	N220
258	Emergency Claim does not match Emergency Benefit	A1	N220
260	Pursue and pay for Professional claims with no information	22	
261	Pursue and pay for Institutional claims with no information	22	
262	Claim requires Pursue and Pay	22	
263	Auto Accident indicated on claim - Pursue and Pay	20	
264	Auto Insurance information on claim - Pursue and Pay	20	
265	Other Insurance indicated on claim - Pursue and Pay	22	
266	Other Insurance information unknown - Pursue and Pay	22	
267	Letter of Inquiry No Response or Outdated - Pursue and Pay	16	
268	COB Coverage Not for Claim Type	22	
269	Benefit requires authorization and has associated penalty	197	
271	Benefit Restriction Group Validation Failed	B5	
272	Member does not have coverage code required on benefit	B5	N30
286	No PCP on DOS	38	
289	Invalid Occurrence Code on DOS	16	M45
290	Invalid Occurrence Span Code on DOS	16	M46
291	Invalid Condition Code on DOS	16	M44
292	Invalid Value Code on DOS	16	M49
300	Duplicate Claim (member/DOS)	18	
301	Invalid or missing admission date	125	MA40
302	Attending Physician Required for Inpatient Claims	125	N253
303	Claim Total Mismatch	125	M54
304	Invalid Bill Type	16	MA30
305	Primary ICD-9 diagnostic code is required	146	M76

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
306	Discharge status is required for inpatient and SNF claims	125	N50
307	Duplicate Claim (Same Provider/Member/DOS)	18	M86
308	Invalid Admit Hour (0 -- 23)	125	N46
309	Invalid Discharge Hour (0 -- 23)	125	N318
311	Claim Submission Window Exceeded [All Claims, header date]	29	
312	Invalid coinsurance days for 11x bill type	125	MA34
313	Covered days do not match accommodation revcode days	125	M53
314	Non-covered days less than leave of absence days	125	M53
315	Invalid Lifetime Reserve Days	125	M53
316	Admit type does not match admit source	125	MA42
317	Other agency may be responsible for payment	A1	N193
318	Invalid coinsurance days for 21x bill type	125	MA34
319	Coinsurance days exceeds covered days	125	MA34
320	Coinsurance days missing associated value codes	125	M49
321	Covered days and coinsured days exceed maximum for hospital	125	MA34
322	Covered days exceeds maximum for hospital	119	MA32
323	Covered days and coinsured days exceed maximum for SNF	119	MA34
324	Covered days exceed maximum for SNF	119	M53
325	Non-covered days exceed statement-covered period	125	M53
326	Life reserve days exceed maximum	35	M53
327	Admit type requires 450 revcode	125	M50
328	Admission Source Required	125	MA42
329	Invalid patient status for bill type	125	MA43
330	Invalid diagnosis code for benefit	11	M64
332	DRG mismatch with DRGActive product	A8	
333	DRGActive Product Error	A8	N220
334	APC/OPPS claim pricing failure	147	
335	HIPPS RUGS DOS is not within assessment modifier time period	125	MA31
336	HIPPS RUGS billed amount should not have a dollar amount	125	M54
337	HIPPS RUG rate code requires rehabilitation therapy	16	M50
338	HIPPS RUGS length of stay not in sync with accommodation day	16	M53
339	APC claim has lines that have rolled up into other lines	B15	
340	HH PPS too many SCICs detected. Manual review is required.	133	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
341	HH PPS No Rap present for claim	A1	N220
342	HH PPS Therapy threshold not met. Fallback used for payment	A1	N220
343	No matching RAP claim lines	A1	N220
344	No previously processed RAP claim lines	A1	N220
345	Detail line REV code not 0023	16	M50
346	Unable to locate fee schedule	147	
347	RAP has more than one detail line	A1	N220
348	Line #1 date must equal episode start date	A1	N220
349	LUPA episode is not 60 days	16	MA31
350	Valid admit date required for HHPPS	125	MA40
351	Credit for prior RAP payment	23	
352	Previous RAP payment exceeds claim amount	23	
353	Detail line REV code not 0022	16	M50
354	Base fee not found or equals $0.00	147	
355	SNF provider missing SNF per diem amount	147	
356	Overlapping RAP episodes	18	
357	HHPPS RAP From and Through DOS not equal	16	MA31
358	Micro-Dyn PricerActive component error	A8	
359	Micro-Dyn DRGActive component error	A8	
360	DRG is NOT in the selected DRG Group	A8	
361	No end date on claim configured for Micro-Dyn PricerActive	125	M59
362	Provider ID NOT valid for MicroDyn PricerActive	125	N290
366	Workers Compensation Claim	19	
367	Contract term requires authorization	197	
374	Medicare Excluded Service - Other Insurance Dollars on Claim	22	
376	Contract Term Restriction Group Validation Failed	16	N180
377	EOB not received on Claim	22	MA04
378	No COB Amount on claim	22	MA04
379	Member has privacy payee defined for claim	A1	N220
380	Other Carrier Paid exceeds Other Carrier Allowed	23	
382	Global payment allocated	97	M15
384	Potential Other Accident	22	N220
400	Gender is invalid for Medical Policy	7	
401	Age is invalid for Medical Policy	6	
402	Maximum units exceeded for Medical Policy	119	
403	Diagnoses invalid for Medical Policy	11	
404	Place of Service invalid for Medical Policy	5	
405	Provider Type is invalid for Medical Policy	170	
406	Physician specialty is invalid for Medical Policy	172	N95

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
407	Modifier(s) is invalid for Medical Policy	4	
408	Line failed for Medical Policy Rule	A1	N220
409	Line failed for Medical Policy rule overridden on Cert	A1	N220
410	History Claim Failed Medical Policy Rule	A1	N220
501	Entry in Local Use field is required	A1	N220
502	Duplicate Line on Same Claim	18	
503	Invalid CPT Modifier	182	
504	Invalid CPT/HCPCS code	181	M51
505	Invalid Revenue Code	16	M50
507	Revenue Code Requires HCPCS	125	M20
508	Invalid Modifier Code on Date of Service	182	
511	Invalid From DOS	125	M52
512	Invalid Thru DOS	125	M59
514	Invalid Revenue Code for Bill Type	16	M50
515	Invalid HCPCS for Revenue Code	199	
516	Surgical Procedure Requires HCPCS	125	M20
518	Admit type required for 11x bill type	125	MA41
519	Duplicate Claim Line (Same Member/DOS/CPT(Rev))	18	
521	Procedure code not found or invalid for date of service	181	
522	Duplicate Claim Line (Same Provider/Member/DOS/CPT(Rev))	18	
523	Invalid ICD-9 diagnosis code	16	M64
524	CPT codes billed include bundled and unbundled CPTs	97	M15
525	ICD-9 diagnosis code is not valid on DOS	146	
526	Claim submitted out of sequence	A1	N220
530	Insufficient units for date span	16	M53
531	Duplicate Mem/DOS/Service code/Pay To/Modifier	18	
532	Duplicate Mem/DOS/Service code/Pay To/Rendering Phys/Modifie	18	
533	Duplicate Mem/DOS/Pay To/Rendering Phys/Charges	18	
534	Duplicate Modifer Exact Match	18	
536	CPT Code is Bundled wth Other CPT	97	M15
538	Diagnosis Pointer Required on Service Line for Diagnosis Codes	16	M64
539	Date of Service beyond Paid Thru Date and Grace Period Date	27	N30
540	Date of Service is during the Grace Period	27	N30
541	Claim Line Submission Window Exceeded	29	
542	Claim Line Submission Window Overlap	45	
543	Inpatient Claim Submission Window Exceeded [header to date]	29	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
552	Claim was paid using the Default Claim Resolution Process		N524
601	Prior Authorization Is Closed	197	
602	Prior Authorization Is Awaiting Medical Review	197	
603	Prior Authorization Is Pended	197	
604	Prior Authorization Is Denied	39	M62
606	Prior authorization number NOT found	15	M62
607	Prior authorization not for same member	15	N54
608	Prior authorization not for same provider	15	
609	Prior authorization dates do not match claim	15	N351
610	Prior Authorization Services do not match claim	15	N54
611	Prior authorization has no available units	198	
612	Prior authorization has insufficient units remaining	198	
613	Claim Requires Manual Processing	133	
614	No Available Bed Days on Auth	198	
615	Claim Line Exceeds Available Bed Days-Partial Units Paid	198	
616	Authorization Line Denied	39	
617	Provider's specialty does not match authorized specialty	172	N95
618	Provider's group does not match authorized group	15	N54
619	Provider's network does not match authorized network	38	
620	Provider's participation status does not match authorized	B7	
621	Provider type does not match authorized provider type	170	
622	Place of Service does not Match Authorized	15	N54
623	NDC Code Mismatch on Authorization	15	N54
624	Authorization Line Manually Denied	39	N54
625	Authorization Line Manually Pended	197	
627	Allow manual setting of Benefit Preference on Auth	133	
628	Claim Line date span crosses calendar/policy year	125	N74
629	Multi unit Claim Line date span crosses calendar/policy year	125	N74
632	No Determining Claims Found	107	
633	A determining claim matched - using that benefit preference	133	
634	Benefit preference selection forced manually through the UI	45	
635	Invalid Claim Form Type	16	N34

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
638	Allow override of contract amt based on benefit preference	45	
641	Multiple Instances of Revenue Code 0024 on Claim	A1	N220
642	Invalid Bill Type found on an IRF claim	125	MA30
643	Multiple or invalid HIPPS codes found on IRF claim	A1	N220
644	Charges were not set to zero on an IRF claim	125	M54
645	Non-covered days reported with code 74 not accurate	125	M53
646	Days must equal payable days + loa days + non-covered days	125	M53
647	Claim line has a revenue code of 018X and a HCPCS/Rate	125	M20
648	Claim line units not = days reflected with span code 74	125	M53
649	Sum of units with accommodation codes not equal covered days	125	M53
650	Charges not equal to daily room rate multiplied by days	125	M54
651	Claim is an interrupted stay	A1	N30
652	Length of stay on claim was less than average length of stay	150	
653	Claim is a short stay	150	
654	Benefits were exhausted during stay	119	N30
655	Benefits were exhausted prior to admission	119	N30
656	Claim is an Interim IRF bill	135	
657	Error encountered with Micro-Dyn IRF Priceractive component	A8	
658	Invalid claim data found on IRF claim	A1	N220
662	Contract for service location on claim was not found	5	M77
700	Invalid Dental Procedure	125	M51
701	Invalid Dental Warranty Period	A1	N220
702	Invalid CDT code on DOS	181	
703	Invalid tooth number	125	N39
704	Invalid tooth surface for tooth	125	N75
705	Submitted code requires billing package	A1	N220
706	CDT already billed on this date by same provider	18	
707	CDT already billed on this date	18	
708	Invalid Tooth for CDT	125	N37
709	CDT requires tooth surface min/max count	125	N75
710	Service Line has been Downcoded	97	N220
711	Replace obsolete code	181	
712	Dental Area/Tooth Mismatch	125	N75
828	Claim Check: Wizard User Defined	A1	N362
911	Invalid For Male	7	
912	Invalid For Female	7	

MIHMS Edit Rules

MIHMS Rule Id	Description	CARC-Claim Adjustment Reason Code	RARC-Remittance Advice Reason Code
913	Manual Pend of Claim	133	
914	Electronic Claim has COB	22	MA04
915	Claim has been manually denied	A1	N220
916	Claim does not have any service lines	16	M51
917	Manually-altered pay amount	A1	N220
918	Connect requires claim review	107	
919	Contract Price on Service Line has been Manually Overridden	A1	N220
920	Contract Price on Service Line Manually Overridden to Zero	A1	N220
921	Claim manually priced with no balance checks or validation	A1	N220
922	Manual Contract Price exceeds Billed Amount on Service Line	A1	N220
991	Claim Document or Information Not Received	125	N463
5011	Provider does not match lock -in provider - Full lock-in	38	
5012	Provider does not match lock -in provider - Partial lock -in	38	
5021	Drug not rebateable	211	
5022	NDC/JCode is Missing/Invalid	A1	M119
5025	Multiple instances of same J Code not allowed for same DOS	A1	M86
5026	Missing Revenue Code for J -Code	199	M50
5027	EyeCare Budget Exceeded	A1	M139
5028	Missing Detailed Drug Coding		M123
5030	FQHC/RHC/Hospital subsequent lines denied	45	N381
5031	Claim must be billed for the entire month	125	N56
6001	Benefit Exhaustion Period Reported	200	
6002	Medicare Crossover QMB Processing Rules Applies	22	MA04
6003	No COB Amount on TPL Dental	22	MA04
6007	Under Review	B7	N95
6008	Under Review	B5	
6010	Invalid Service Location Selection	16	N79
6017	Spenddown	178	
6018	Medically Unlikely	151	N431
6019	No Benefit for Crossover Services	204	
6023	TOB frequency of zero	96	N356
6024	Crossover Hospital Pricing Rules Applied	192	MA46
6025	No TPL Dollars Submitted on Medicare Claim	22	MA04
6027	Fiscal Pend	143	MA106