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<tr>
<td>G1</td>
<td>Provider's charge exceeds fee schedule allowance.</td>
<td>The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.</td>
<td></td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td></td>
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</tr>
<tr>
<td>G2</td>
<td>The OMFS does not include a code for the billed service.</td>
<td>The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.</td>
<td>Indicate code for comparable service.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N448</td>
<td>This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.</td>
</tr>
<tr>
<td>G3</td>
<td>The OMFS does not list the code for the billed service.</td>
<td>The Official Medical Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation.</td>
<td></td>
<td>220</td>
<td>The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4</td>
<td>Billed charges exceed amount identified in your contract.</td>
<td>This charge was adjusted to comply with the rate and rules of the contract indicated.</td>
<td>Requires name of specific Contractual agreement from which the re-imbursement rate and/or payment rules were derived.</td>
<td>45</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).</td>
<td></td>
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</tr>
<tr>
<td>G5</td>
<td>No standard EOR message applies.</td>
<td>This charge was adjusted for the reasons set forth in the attached letter.</td>
<td>Message to be used when no standard EOR message applies and additional communication is required to provide clear and concise reason(s) for adjustment/denial.</td>
<td>162</td>
<td>State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.</td>
<td>M118</td>
<td>Alert: Letter to follow containing further information</td>
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<tr>
<td>G6</td>
<td>Provider charges for service that has no value.</td>
<td>According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
<td></td>
</tr>
<tr>
<td>G7</td>
<td>Provider bills for a service included within the value of another.</td>
<td>No separate payment was made because the value of the service is included within the value of another service performed on the same day.</td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td></td>
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</tr>
<tr>
<td>G8</td>
<td>Provider billed for a separate procedure that is included in the total service rendered.</td>
<td>A charge was made for a &quot;separate procedure&quot; that does not meet the criteria for separate payment. See Physician’s Fee Schedule General Instructions for Separate Procedures rule.</td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
<td></td>
</tr>
<tr>
<td>G9</td>
<td>Provider submitted bill with no supporting or lack of sufficient identification or documentation for the unlisted or BR Service reported.</td>
<td>The unlisted or BR service was not received or sufficiently identified or documented. We are unable to make a payment without supplementary documentation giving a clearer description of the service. See OMFS General Instructions for Procedures Without Unit Values</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N350</td>
<td>Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. [Note: If specific documentation is needed, use the specific RARC for the report needed.]</td>
<td></td>
</tr>
<tr>
<td>G10</td>
<td>Bill is submitted without necessary documentation needed for bill processing.</td>
<td>We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N29</td>
<td>Missing documentation/orders/notes/summary/report/chart. [Note: Only use RARC N29 if none of the more specific RARC report type codes below apply. (G11 – G52)]</td>
<td></td>
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<td>G11</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>M30</td>
<td>Missing pathology report.</td>
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<td>G12</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N236</td>
<td>Incomplete/invalid pathology report.</td>
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<td>G13</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N240</td>
<td>Incomplete/invalid radiology report.</td>
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<td>G14</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>M31</td>
<td>Missing radiology report.</td>
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<td>G15</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N451</td>
<td>Missing Admission Summary Report.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N452</td>
<td>Incomplete/Invalid Admission Summary Report.</td>
</tr>
<tr>
<td>G17</td>
<td></td>
<td>If the payer needs documentation supporting a prescription that was Dispensed As Written, a request for additional information should be sent to the prescribing physician.</td>
<td></td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>M118</td>
<td>Alert: Letter to follow containing further information</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N456</td>
<td>Incomplete/Invalid Physician Order.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N455</td>
<td>Missing Physician Order.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N497</td>
<td>Missing Medical Permanent Impairment or Disability Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N499</td>
<td>Missing Medical Legal Report.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>N501</td>
<td>Missing Vocational Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>Incomplete/Invalid Vocational Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N503</td>
<td>Missing Work Status Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>Incomplete/Invalid Work Status Report</td>
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<td>Missing Consultation Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N454</td>
<td>Incomplete/Invalid Consultation Report</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N26</td>
<td>Missing Itemized Bill/ Statement</td>
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<td>N455</td>
<td>Missing Physician's Report- Delete Comments</td>
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<td>Incomplete/invalid progress notes/report.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>Missing progress notes/report.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>Incomplete/invalid laboratory report.</td>
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<td>Missing laboratory report.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
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<td>Incomplete/Invalid Diagnostic Report.</td>
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<td>Missing Diagnostic Report.</td>
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<td>N460</td>
<td>Incomplete/Invalid Discharge Summary.</td>
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<td>Missing Discharge Summary.</td>
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<td>N462</td>
<td>Incomplete/Invalid Nursing Notes.</td>
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<td>N461</td>
<td>Missing Nursing Notes.</td>
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<td>N464</td>
<td>Incomplete/Invalid support data for claim.</td>
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<td>N463</td>
<td>Missing support data for claim.</td>
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<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N466</td>
<td>Incomplete/Invalid Physical Therapy Notes.</td>
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### 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

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<td>G46</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N465</td>
<td>Missing Physical Therapy Notes.</td>
</tr>
<tr>
<td>G47</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N468</td>
<td>Incomplete/Invalid Report of Tests and Analysis Report.</td>
</tr>
</tbody>
</table>
### 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

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<tr>
<td>G48</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td></td>
<td>N467 Missing Report of Tests and Analysis Report.</td>
<td></td>
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</tr>
<tr>
<td>G49</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td></td>
<td>N493 Missing Doctor First Report of Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G50</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td></td>
<td>N494 Incomplete/invalid Doctor First Report of Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G51</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td></td>
<td>N495 Missing Supplemental Medical Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G52</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td></td>
<td>N496 Incomplete/invalid Supplemental Medical Report</td>
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<tr>
<td>G53</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>175 Prescription is incomplete</td>
<td>N378</td>
<td>Missing/incomplete/invalid prescription quantity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>176 Prescription is not current</td>
<td>N388</td>
<td>Missing/incomplete/invalid prescription number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CARC 175 and 176 may be used with any of the listed RARC Codes</td>
<td>N349</td>
<td>The administration method and drug must be reported to adjudicate this service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N389</td>
<td>Duplicate prescription number submitted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M123</td>
<td>Missing/incomplete/invalid name, strength, or dosage of the drug furnished.</td>
</tr>
<tr>
<td>G54</td>
<td></td>
<td>Provider's documentation and/or code does not support level of service billed</td>
<td>This service appears to be unrelated to the patient's diagnosis.</td>
<td></td>
<td>Indicate alternate OMFS code on which payment amount is based.</td>
<td>150</td>
<td>Payer deems the information submitted does not support this level of service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N22</td>
<td>This procedure code was added/changed because it more accurately describes the services rendered.</td>
</tr>
<tr>
<td>G55</td>
<td></td>
<td>Provider bills for service that is not related to the diagnosis.</td>
<td>This service appears to be unrelated to the patient's diagnosis.</td>
<td></td>
<td>The diagnosis is inconsistent with the procedure.</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>G56</td>
<td></td>
<td>Provider bills a duplicate charge.</td>
<td>This service appears to be a duplicate charge for a bill previously reviewed, or this appears to be a “balance forward bill” containing a duplicate charge and billing for a new service.</td>
<td></td>
<td>Indicate date original charge was reviewed for payment. This code may be used to reject a bill that is a complete duplicate or to reject an entire bill that fits the definition of “balance forward bill” under section 5.0 (c).</td>
<td>18</td>
<td>Duplicate claim/service.</td>
</tr>
<tr>
<td>G57</td>
<td></td>
<td>Service or procedure requires prior authorization and none was identified.</td>
<td>This service requires prior authorization and none was identified.</td>
<td></td>
<td></td>
<td>197</td>
<td>Precertification/authorization/notification absent.</td>
</tr>
<tr>
<td>G58</td>
<td></td>
<td>Provider bills separately for report included as part of another service.</td>
<td>Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.</td>
<td></td>
<td>Message shall not be used to deny separately reimbursable special and/or duplicate reports requested by the payer.</td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>N390</td>
<td>This service/report cannot be billed separately.</td>
</tr>
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<tr>
<td>G59</td>
<td>Provider bills inappropriate modifier code.</td>
<td>The appended modifier code is not appropriate with the service billed.</td>
<td>If modifier is incorrect, billed. OMFS code should still be considered for payment either without use of the modifier or with adjustment by the reviewer to the correct modifier, when the service is otherwise payable. Indicate alternative modifier if assigned.</td>
<td>4. The procedure code is inconsistent with the modifier used or a required modifier is missing.</td>
<td></td>
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</tr>
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<tr>
<td>G60</td>
<td>Billing is for a service unrelated to the work illness or injury.</td>
<td>Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury.</td>
<td></td>
<td>191</td>
<td>Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G61</td>
<td>Provider did not document the service that was performed.</td>
<td>The charge was denied as the report / documentation does not indicate that the service was performed.</td>
<td></td>
<td>112</td>
<td>Service not furnished directly to the patient and/or not documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G62</td>
<td>Provider inappropriately billed for emergency services.</td>
<td>Reimbursement was made for a follow-up visit, as the documentation did not reflect an emergency.</td>
<td></td>
<td>40</td>
<td>Charges do not meet qualifications for emergent/urgent care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G63</td>
<td>Provider bills for services outside his/her scope of practice.</td>
<td>The billed service falls outside your scope of practice.</td>
<td></td>
<td>8</td>
<td>The procedure code is inconsistent with the provider type/specialty (taxonomy).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G64</td>
<td>Provider charge of professional and/or technical component is submitted after global payment made to another provider.</td>
<td>Provider charge of professional and/or technical component is submitted after global payment made to another provider.</td>
<td></td>
<td>134</td>
<td>Technical fees removed from charges.</td>
<td></td>
<td></td>
</tr>
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<td>G65</td>
<td>Provider charge of professional and/or technical component is submitted after global payment made to another provider.</td>
<td>Provider charge of professional and/or technical component is submitted after global payment made to another provider.</td>
<td>Indicate name of other provider who received global payment.</td>
<td>89</td>
<td>Professional fees removed from charges.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>G66</td>
<td>Timed code is billed without documentation.</td>
<td>Documentation of the time spent performing this service is needed for further review.</td>
<td></td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N443</td>
<td>Missing/incomplete/invalid total time or begin/end time.</td>
</tr>
<tr>
<td>G67</td>
<td>Charge is for a different amount than what was pre-negotiated.</td>
<td>Payment based on individual pre-negotiated agreement for this specific service.</td>
<td>Identify name of specific contracting entity, authorization # if provided, and pre-negotiated fee or terms. This EOR is for individually negotiated items/</td>
<td>131</td>
<td>Claim specific negotiated discount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G68</td>
<td>Charge submitted for service in excess of pre-authorization.</td>
<td>Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original authorization.</td>
<td></td>
<td>198</td>
<td>Precertification/authorization exceeded.</td>
<td>N435</td>
<td>Exceeds number/frequency approved/allowed within time period without supporting documentation.</td>
</tr>
<tr>
<td>G69</td>
<td>Charge is made by provider outside of HCO or MPN.</td>
<td>Payment is denied as the service was provided outside the designated Network.</td>
<td>Indicate name of HCO or MPN designated network. This message is not to be used to deny payment to out-of-network providers when the employee is legally allowed to treat out of network. For example: when the employer refers the injured worker to the provider.</td>
<td>38</td>
<td>Services not provided or authorized by designated (network/primary care) providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G70</td>
<td>Charge denied during Prospective or Concurrent Utilization Review</td>
<td>This charge is denied as the service was not authorized during the Utilization Review process. If you disagree, please contact our Utilization Review Unit.</td>
<td>Optional: Provide Utilization Review phone number.</td>
<td>39</td>
<td>Services denied at the time authorization/pre-certification was requested.</td>
<td>N175</td>
<td>Missing review organization approval.</td>
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<tr>
<td>G71</td>
<td>Charge denied during a Retrospective Utilization Review.</td>
<td>This charge was denied as part of a Retrospective Review. If you disagree, please contact our Utilization Review Unit.</td>
<td>Optional: Provide Utilization Review phone number.</td>
<td>216</td>
<td>Based on the findings of a review organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G72</td>
<td>Charge being submitted for Retrospective Review</td>
<td>This charge is being sent to Retrospective Review as there is no indication that prior authorization has been sought.</td>
<td></td>
<td>15</td>
<td>The authorization number is missing, invalid, or does not apply to the billed service</td>
<td>N175</td>
<td>Missing review organization approval</td>
</tr>
<tr>
<td>G73</td>
<td>Provider bills with missing, invalid or inappropriate authorization number</td>
<td>Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.</td>
<td></td>
<td>15</td>
<td>The authorization number is missing, invalid, or does not apply to the billed service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G74</td>
<td>Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete</td>
<td>Requested documentation to support the bill was absent or incomplete.</td>
<td>Identify the necessary items.</td>
<td>226</td>
<td>Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)</td>
<td>N66</td>
<td>Missing/incomplete/invalid documentation.</td>
</tr>
<tr>
<td>G75</td>
<td>Provider bills payer/employer when there is no claim on file</td>
<td>Bill payment denied as the patient cannot be identified as having a claim against this claims administrator.</td>
<td></td>
<td>A1</td>
<td>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.)</td>
<td>MA61</td>
<td>Missing/in-complete/invalid social security number or health insurance claim number.</td>
</tr>
<tr>
<td>G76</td>
<td>Provider bills for services that are not medically necessary</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer.</td>
<td></td>
<td>50</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G77</td>
<td>Provider submits bill to incorrect payer/contactor</td>
<td>Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.</td>
<td></td>
<td>109</td>
<td>Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.</td>
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<tr>
<td>G78</td>
<td>Provider bills for multiple services with no or inadequate information to support this many services.</td>
<td>Payment adjusted because the payer deems the information submitted does not support this many services.</td>
<td></td>
<td>151</td>
<td>Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G79</td>
<td>Bill exceeds or is received after $10,000 cap has been reached on a delayed claim</td>
<td>This claim has not been accepted and the mandatory $10,000 medical reimbursements have been made. Should the claim be accepted, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.</td>
<td>119</td>
<td>Benefit maximum for this time period or occurrence has been reached.</td>
<td>N436</td>
<td>The injury claim has not been accepted and a mandatory medical reimbursement has been made. For additional clarification to the provider, use Remark Code N437 – Alert: If the injury claim is accepted, these charges will be reconsidered.</td>
<td></td>
</tr>
<tr>
<td>G80</td>
<td>Bill is submitted that is for a greater amount than remains in the $10,000 cap.</td>
<td>Until the employee’s claim is accepted or rejected, liability for medical treatment is limited to $10,000 (Labor Code § 5402(c)). Your bill is being partially paid as this payment will complete the Labor Code § 5402(c) mandatory $10,000 reimbursement. Should the claim be accepted, your bill will then be reconsidered. This determination must be made by 90 days from the date of injury but may be made sooner.</td>
<td>119</td>
<td>Benefit maximum for this time period or occurrence has been reached.</td>
<td>N437</td>
<td>Alert: If the injury claim is accepted, these charges will be reconsidered.</td>
<td></td>
</tr>
<tr>
<td>G81</td>
<td>Payer is paying self-executing penalties and interest to the provider due to late payment.</td>
<td>This bill has been paid beyond the time frame required under L.C. 4602.3. Per Section 7.2 (b) penalties and interest are self-executing</td>
<td>Add 15% penalty and appropriate interest to the payment.</td>
<td>225</td>
<td>Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Note: for CA workers’ compensation, ignore the parenthetical section.</td>
<td></td>
<td></td>
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<tr>
<td>PM1</td>
<td>Non-RPT provider bills Physical Therapy Assessment and Evaluation code.</td>
<td>This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.</td>
<td></td>
<td>8</td>
<td>The procedure code is inconsistent with the provider type/specialty (taxonomy).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM2</td>
<td>Provider bills both E/M or A/E, and test and measurement codes on the same day.</td>
<td>Documentation justifying charges for both test and measurements and evaluation and management or assessment and evaluation on the same day is required in accordance with Physical Medicine rule 1 (h).</td>
<td></td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N435</td>
<td>Exceeds number/ frequency approved/allowed within time period without support documentation.</td>
</tr>
<tr>
<td>PM3</td>
<td>Provider bills three or more modalities only, in same visit.</td>
<td>When billing for modalities only, you are limited to two modalities in any single visit pursuant to Physical Medicine rule 1 (b). Payment has been made in accordance with Physician Fee Schedule guidelines.</td>
<td></td>
<td>119</td>
<td>Benefit maximum for this time period or occurrence has been reached.</td>
<td>N362</td>
<td>The number of Days or Units of Service exceeds our acceptable maximum.</td>
</tr>
<tr>
<td>PM4</td>
<td>Provider bills &quot;additional 15 minute&quot; code without billing the &quot;initial 30 minute&quot; base code.</td>
<td>This physical medicine extended time service was billed without the &quot;initial 30 minutes&quot; base code.</td>
<td></td>
<td>107</td>
<td>The related or qualifying claim/service was not identified on this claim.</td>
<td>N122</td>
<td>Add-on code cannot be billed by itself.</td>
</tr>
<tr>
<td>DWC Bill Adjustment Reason Code</td>
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<td><strong>PHYSICAL MEDICINE</strong></td>
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</tr>
<tr>
<td>PM5</td>
<td>Provider bills a second physical therapy A/E within 30 days of the last evaluation.</td>
<td>Only one assessment and evaluation is reimbursable within a 30 day period. The provider has already billed for a physical therapy evaluation within the last 30 days. See Physical Medicine rule 1 (a).</td>
<td></td>
<td></td>
<td>119 Benefit maximum for this time period or occurrence has been reached.</td>
<td></td>
<td>N130 Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>PM6</td>
<td>Provider billing exceeds 60 minutes of physical medicine or acupuncture services.</td>
<td>Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to Physical Medicine rule 1 (c).</td>
<td></td>
<td></td>
<td>119 Benefit maximum for this time period or occurrence has been reached.</td>
<td></td>
<td>N362 The number of Days or Units of Service exceeds our acceptable maximum.</td>
</tr>
<tr>
<td>PM7</td>
<td>Provider bills more than four physical medicine procedures and/or chiropractic manipulation and/or acupuncture codes during the same visit without prior authorization.</td>
<td>No more than four physical medicine procedures including Chiropractic Manipulation and Acupuncture codes are reimbursable during the same visit without prior authorization pursuant to Physical Medicine rule 1 (d).</td>
<td></td>
<td></td>
<td>151 Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.</td>
<td></td>
<td>N362 The number of Days or Units of Service exceeds our acceptable maximum.</td>
</tr>
<tr>
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</tr>
<tr>
<td>PM8</td>
<td>Provider bills full value for services subject to the multiple service cascade.</td>
<td>Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.</td>
<td></td>
<td></td>
<td>59 Processed based on multiple or concurrent procedure rules.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM9</td>
<td>Provider bills office visit in addition to physical medicine/acupuncture code or OMT/CMT code at same visit. Specified special circumstances not applicable.</td>
<td>Billing for evaluation and management service in addition to physical medicine/acupuncture code or OMT/CMT code resulted in a 2.4 unit value deduction from the treatment codes in accordance with Physical Medicine rule 1 (g).</td>
<td></td>
<td></td>
<td>59 Processed based on multiple or concurrent procedure rules.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>PM10</td>
<td>Provider fails to note justification for follow-up E/M charge during treatment.</td>
<td>Payment for this service was denied because documentation of the circumstances justifying both a follow-up evaluation and management visit and physical medicine treatment has not been provided as required by physical medicine rule 1 (f).</td>
<td></td>
<td></td>
<td>W1 Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N435</td>
<td>Exceeds number/frequency approved /allowed within time period without support documentation.</td>
</tr>
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### 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

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<tr>
<td>PM11</td>
<td>Physical Therapist charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.</td>
<td>Charge was denied as Physical Therapists may not bill Evaluation and Management services.</td>
<td></td>
<td></td>
<td>170      Payment is denied when performed/billed by this type of provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM12</td>
<td>Pre-surgical visits in excess of 24 are charged without prior authorization for additional visits.</td>
<td>Charge is denied as there is a 24 visit limitation on pre-surgical Physical Therapy, Chiropractic and Occupational Therapy encounters for injuries on/after January 1, 2004 without prior authorization for additional visits.</td>
<td></td>
<td></td>
<td>Optional: Provide Utilization Review phone number.</td>
<td></td>
<td>198 Precertification/authorization exceeded.</td>
</tr>
</tbody>
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### 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

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<tr>
<th>DWC Bill Adjustment Reason Code SURGERY</th>
<th>Issue</th>
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<tbody>
<tr>
<td>S1</td>
<td>Physician billing exceeds fee schedule guidelines for multiple surgical services.</td>
<td>Recommended payment reflects Physician Fee Schedule Surgery Section, rule 7 guidelines for multiple or bi-lateral surgical services.</td>
<td></td>
<td>59</td>
<td>Processed based on multiple or concurrent procedure rules.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>Physician billed for initial casting service included in value of fracture or dislocation reduction allowed on the same day.</td>
<td>The value of the initial casting service is included within the value of a fracture or dislocation reduction service.</td>
<td></td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>Physician bills office visit or service which is not separately reimbursable as it is within the global surgical period.</td>
<td>The visit or service billed, occurred within the global surgical period and is not separately reimbursable.</td>
<td></td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td>M144</td>
<td>Pre-/post-operative care payment is included in the allowance for the surgery/procedure.</td>
</tr>
<tr>
<td>S4</td>
<td>Multiple arthroscopic services to same joint same session are billed at full value.</td>
<td>Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to Surgery Section, rule 7 re: Arthroscopic Services.</td>
<td></td>
<td>59</td>
<td>Processed based on multiple or concurrent procedure rules.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
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</tr>
<tr>
<td>SURGERY</td>
<td>S5</td>
<td>This initial visit was converted to code 99025 in accordance with the starred service Surgery Section, rule 10 (b) (1).</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N22</td>
<td>This procedure code was added/changed because it more accurately describes the services rendered.</td>
<td></td>
</tr>
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</tr>
<tr>
<td>SURGERY</td>
<td>S6</td>
<td>Assistant Surgeon charged greater than 20% of the surgical procedure.</td>
<td>Assistant Surgeon services have been reimbursed at 20% of the surgical procedure. (See Modifier 80 in the Surgery Section of the Physician’s Fee Schedule).</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
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<tr>
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<td></td>
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<td></td>
</tr>
<tr>
<td>S10</td>
<td>Surgeon’s bill includes separate charge for delivery of local anesthetic.</td>
<td>Administration of Local Anesthetic is included in the Surgical Service per Surgery Section, rule 16.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment</td>
<td>N514</td>
<td>Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
<td></td>
</tr>
<tr>
<td>S11</td>
<td>Procedure does not normally require an Assistant surgeon or multiple surgeons and no documentation was provided to substantiate a need in this case.</td>
<td>Assistant surgeon services have been denied as not normally warranted for this procedure according to the listed citation.</td>
<td>Identify the reference source listing of approved Assistant Surgeon services.</td>
<td>54</td>
<td>Multiple physicians/ assistants are not covered in this case.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
</tr>
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</tr>
<tr>
<td>A1</td>
<td>Physician bills for additional anesthesia time units not allowed by schedule</td>
<td>Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Physician Fee Schedule, time units are not reimbursed.</td>
<td></td>
<td></td>
<td>97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>A2</td>
<td>No anesthesia records provided for payment determination.</td>
<td>Please submit anesthesia records for further review.</td>
<td></td>
<td></td>
<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N463</td>
<td>Missing support data for claim.</td>
</tr>
<tr>
<td>A3</td>
<td>Insufficient information provided for payment determination.</td>
<td>Please submit complete/valid anesthesia records for further review.</td>
<td></td>
<td></td>
<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N464</td>
<td>Incomplete/invalid support data for claim.</td>
</tr>
<tr>
<td>A4</td>
<td>Insufficient information provided for payment determination.</td>
<td>Please submit anesthesia records time units for further review.</td>
<td></td>
<td></td>
<td>16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N203</td>
<td>Missing/incomplete/invalid anesthesia time/units</td>
</tr>
</tbody>
</table>
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<tbody>
<tr>
<td><strong>ANESTHESIA</strong></td>
<td>A5</td>
<td>Documentation does not describe emergency status.</td>
<td>Qualifying circumstances for emergency status not established.</td>
<td>40</td>
<td>Charges do not meet qualifications for emergent/urgent care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A6</td>
<td>Documentation does not describe physical status/condition.</td>
<td>Patient’s physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>N439</td>
<td>Missing anesthesia physical status report/indicators.</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td>N440</td>
<td>Incomplete/invalid anesthesia physical status report/indicators.</td>
</tr>
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<td>E/M</td>
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</tr>
<tr>
<td>EM1</td>
<td>Physician bills for office visit which is already included in a service performed on the same day.</td>
<td>No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&amp;M service performed with other services provided on the same day.</td>
<td>This EOR should only be used if documentation does not support the use of modifier 25, 57, or 59.</td>
<td>95</td>
<td>Plan procedures not followed.</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
</tr>
<tr>
<td>EM2</td>
<td>Documentation does not support Consultation code.</td>
<td>The billed service does not meet the requirements of a Consultation (See the General Information and Instructions Section of the Physician’s Fee Schedule).</td>
<td></td>
<td>150</td>
<td>Payer deems the information submitted does not support this level of service.</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>EM3</td>
<td>Documentation does not support billing for Prolonged Services code.</td>
<td>Documentation provided does not justify payment for a Prolonged Evaluation and Management service.</td>
<td></td>
<td>152</td>
<td>Payer deems the information submitted does not support this length of service.</td>
<td></td>
<td></td>
</tr>
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<tr>
<td>CL1</td>
<td>Physician bills for individual service normally part of a panel.</td>
<td>This service is normally part of a panel and is reimbursed under the appropriate panel code.</td>
<td></td>
<td>97</td>
<td>The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated.</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
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<tr>
<td>P1</td>
<td>Charge for Brand Name was submitted without “No Substitution” documentation.</td>
<td>Payment was made for a generic equivalent as “No Substitution” documentation was absent.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N447</td>
<td>Payment is based on a generic equivalent as required documentation was not provided.</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Provider charges a dispensing fee for over-the-counter medication or medication administered at the time of the visit</td>
<td>A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit</td>
<td>91</td>
<td>Dispensing fee adjustment.</td>
<td></td>
<td></td>
<td></td>
</tr>
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</tr>
<tr>
<td>DME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>108 Rent/purchase guidelines were not met.</td>
<td></td>
<td>Incomplete/invalid document for actual cost or paid amount.</td>
</tr>
<tr>
<td>DME1</td>
<td>Billed amount exceeds formula using documented actual cost for DMEPOS</td>
<td>Payment for this item was based on the documented actual cost.</td>
<td></td>
<td>108</td>
<td>Rent/purchase guidelines were not met.</td>
<td>N446</td>
<td>Missing document for actual cost or paid amount.</td>
</tr>
<tr>
<td>DME2</td>
<td>Billed amount exceeds formula using documented actual cost for DMEPOS</td>
<td>Payment for this item was based on the documented actual cost.</td>
<td></td>
<td>108</td>
<td>Rent/purchase guidelines were not met.</td>
<td>N445</td>
<td>Missing document for actual cost or paid amount.</td>
</tr>
<tr>
<td>DME3</td>
<td>Billing for purchase is received after cost of unit was paid through rental charges.</td>
<td>Charge is denied as total rental cost of DME has met or exceeded the purchase price of the unit.</td>
<td></td>
<td>108</td>
<td>Rent/purchase guidelines were not met.</td>
<td></td>
<td></td>
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<th>CA Payer Instructions</th>
<th>CARC</th>
<th>Claims Adjustment Reason Code Descriptions (CARC)</th>
<th>RARC</th>
<th>Remittance Advice Remark Code Descriptions (RARC)</th>
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<tr>
<td>DME</td>
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</tr>
<tr>
<td>DME4</td>
<td></td>
<td>Billed amount exceeds formula using documented actual cost for DMEPOS</td>
<td>Payment for this item was based on the documented actual cost.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF).</td>
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<td>DWC Bill Adjustment Reason Code</td>
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<tr>
<td>SPECIAL SERVICES</td>
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<td></td>
</tr>
<tr>
<td>SS1</td>
<td>A physician, other than the Primary Treating Physician or designee submits a Progress and or Permanent and Stationary Report for reimbursement.</td>
<td>The Progress report and or Permanent and Stationary Report were disallowed as you are not the Primary Treating Physician or his/her designee.</td>
<td>B7</td>
<td>This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N450</td>
<td>Covered only when performed by the primary treating physician or the designee.</td>
<td></td>
</tr>
<tr>
<td>SS2</td>
<td>Non-reimbursable report is billed.</td>
<td>This report does not fall under the guidelines for a Separately Reimbursable Report found in the General Instructions Section of the Physician's Fee Schedule.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N390</td>
<td>This service/report cannot be billed separately.</td>
<td></td>
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### 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

<table>
<thead>
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<td>SPECIAL SERVICES</td>
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<tr>
<td>SS3</td>
<td>No request was made for Chart Notes or Duplicate Report.</td>
<td>Chart Notes/Duplicate Reports were not requested.</td>
<td></td>
<td>96</td>
<td>Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td></td>
<td>This service/report cannot be billed separately.</td>
</tr>
<tr>
<td>SS4</td>
<td>Missed appointment is billed.</td>
<td>No payment is being made, as none is necessarily owed</td>
<td></td>
<td></td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF).</td>
<td></td>
<td>This missed appointment is not covered.</td>
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# 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

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<tr>
<td><strong>FACILITY</strong></td>
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<tr>
<td>F1</td>
<td></td>
<td>Procedure is on the Inpatient Only list. Needs advanced authorization in order to be performed on an outpatient basis.</td>
<td>No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted.</td>
<td></td>
<td>197 Precertification/authorization/notification absent.</td>
<td></td>
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<tr>
<td>F2</td>
<td></td>
<td>Charge submitted for facility treatment room for non-emergent service.</td>
<td>Treatment rooms used by the physician and/or hospital treatment rooms for non-emergency services are not reimbursable per the Physician’s Fee Schedule Guidelines.</td>
<td></td>
<td>40 Charges do not meet qualifications for emergent/urgent care.</td>
<td></td>
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<tr>
<td>DWC Bill Adjustment Reason Code</td>
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<tr>
<td><strong>FACILITY</strong></td>
<td>F3</td>
<td>Paid under a different fee schedule.</td>
<td>Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.</td>
<td>Specify which other fee schedule.</td>
<td>W1 Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N442 Payment based on an alternate fee schedule.</td>
<td></td>
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</tr>
<tr>
<td>FACILITY</td>
<td>F4</td>
<td>No payment required under Outpatient Facility Fee Schedule</td>
<td>Service not paid under Outpatient Facility Fee Schedule</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>130</td>
<td>Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.</td>
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<tr>
<td>DWC Bill Adjustment Reason Code</td>
<td>Issue</td>
<td>DWC Explanatory Message</td>
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<tr>
<td>F5</td>
<td>Billing submitted without HCPCS codes</td>
<td>In accordance with OPPS guidelines billing requires HCPCS coding.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>M20</td>
<td>Missing/incomplete/invalid HCPCS.</td>
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<tr>
<td>FACILITY</td>
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<td>Issue</td>
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</tr>
<tr>
<td>F6</td>
<td>Facility has not filed for High Cost Outlier reimbursement formula.</td>
<td></td>
<td>This facility has not filed the Election for High Cost Outlier form with the Division of Workers’ Compensation. The bill will be reimbursed using the regular reimbursement methodology.</td>
<td>W1</td>
<td>Workers’ compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
<td>N444</td>
<td>Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers’ Compensation.</td>
</tr>
<tr>
<td>DWC Bill Adjustment Reason Code</td>
<td>Issue</td>
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</tr>
<tr>
<td>M1</td>
<td>Bill submitted for non compensable claim</td>
<td>Workers’ compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.</td>
<td>214</td>
<td>Workers’ Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier ‘IG’) for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers’ Compensation only.</td>
<td></td>
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</tr>
<tr>
<td>DWC Bill Adjustment Reason Code</td>
<td>Issue</td>
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<tr>
<td>MISC.</td>
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<td></td>
</tr>
<tr>
<td>M2</td>
<td>Appeal /Reconsideration</td>
<td>No additional reimbursement allowed after review of appeal/reconsideration.</td>
<td></td>
<td></td>
<td>193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Third Party Subrogation</td>
<td>Reduction/denial based on subrogation of a third party settlement.</td>
<td></td>
<td></td>
<td>215 Based on subrogation of a third party settlement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M4</td>
<td>Claim is under investigation</td>
<td>Extent of injury not finally adjudicated. Claim is under investigation.</td>
<td></td>
<td></td>
<td>221 Workers’ Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier ‘IG’) for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).</td>
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</tr>
</thead>
<tbody>
<tr>
<td>MISC.</td>
<td>M5</td>
<td>Medical Necessity Denial. You may submit a request for an appeal/reconsideration.</td>
<td>Medical Necessity Denial. You may submit a request for an appeal/reconsideration.</td>
<td>50</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M6</td>
<td>Appeal/ Reconsideration denied based on medical necessity.</td>
<td></td>
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<tr>
<td>M7</td>
<td>This claim is the responsibility of the employer. Please submit directly to employer.</td>
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<td></td>
<td>109</td>
<td>Claim not covered by this payer/ contractor. You must send the claim to the correct payer/ contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Medical Necessity Denial

- **M5**: Medical Necessity Denial. You may submit a request for an appeal/reconsideration. 
  - **CARC**: 50 These are non-covered services because this is not deemed a 'medical necessity' by the payer.

## Appeal/Reconsideration Denied Based on Medical Necessity

- **M6**: Appeal/Reconsideration denied based on medical necessity.
  - **CARC**: 50 These are non-covered services because this is not deemed a 'medical necessity' by the payer.

## This Claim is the Responsibility of the Employer

- **M7**: This claim is the responsibility of the employer. Please submit directly to employer.
  - **CARC**: 109 Claim not covered by this payer/ contractor. You must send the claim to the correct payer/ contractor. (CARC) 109 is to be used with qualifier PR in NM1 to indicate the employer entity.
## 2.0 Matrix List in CARC Order

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