

Denial Reason (CARC)	Effective Date	End Date	Description
100	5/6/2020	12/31/2299	PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS
119	5/6/2020	12/31/2299	BEEN REACHED.
134	5/6/2020	12/31/2299	TECHNICAL FEES REMOVED FROM CHARGES.
135	5/6/2020	12/31/2299	CLAIM DENIED. INTERIM BILLS CANNOT BE PROCESSED. LIFETIME BENEFIT MAXIMUM HAS BEEN REACHED FOR THIS
149	5/6/2020	12/31/2299	SERVICE/BENEFIT CATEGORY.
157	5/6/2020	12/31/2299	SERVICE/PROCEDURE WAS PROVIDED AS A RESULT OF AN ACT OF
158	5/6/2020	12/31/2299	SERVICE/PROCEDURE WAS PROVIDED OUTSIDE OF THE UNITED
159	5/6/2020	12/31/2299	SERVICE/PROCEDURE WAS PROVIDED AS A RESULT OF TERRORISM. INJURY/ILLNESS WAS THE RESULT OF AN ACTIVITY THAT IS A BENEFIT
160	5/6/2020	12/31/2299	EXCLUSION. THESE SERVICES WERE SUBMITTED AFTER THIS PAYERS
166	5/6/2020	12/31/2299	RESPONSIBILITY FOR PROCESSING CLAIMS UNDER THIS PLAN THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER
167	5/6/2020	12/31/2299	TO THE 835 HEALTHCARE POLICY IDENTIFIC SERVICE(S) HAVE BEEN CONSIDERED UNDER THE PATIENT'S MEDICAL
168	5/6/2020	12/31/2299	PLAN. BENEFITS ARE NOT AVAILABLE UNDER T
170	5/6/2020	12/31/2299	PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF
171	5/6/2020	12/31/2299	PROVIDER. USAGE: REFER TO THE 835 HEALTHCARE
172	5/6/2020	12/31/2299	PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF
177	5/6/2020	12/31/2299	PROVIDER IN THIS TYPE OF FACILITY. USAGE: RE
178	5/6/2020	12/31/2299	PAYMENT IS ADJUSTED WHEN PERFORMED/BILLED BY A PROVIDER OF THIS SPECIALTY. USAGE: REFER TO THE 835 H
180	5/6/2020	12/31/2299	PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY REQUIREMENTS. PATIENT HAS NOT MET THE REQUIRED SPEND DOWN
181	5/6/2020	12/31/2299	REQUIREMENTS.
182	5/6/2020	12/31/2299	PATIENT HAS NOT MET THE REQUIRED RESIDENCY REQUIREMENTS. PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE.
185	5/6/2020	12/31/2299	PROCEDURE MODIFIER WAS INVALID ON THE DATE OF SERVICE. THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE
191	5/6/2020	12/31/2299	SERVICE BILLED. USAGE: REFER TO THE 835 HEALTH
200	5/6/2020	12/31/2299	CLAIM DENIED BECAUSE THIS IS NOT A WORK RELATED INJURY/ILLNESS AND THUS NOT THE LIABILITY OF THE WOR EXPENSES INCURRED DURING LAPSE IN COVERAGE.
201	5/6/2020	12/31/2299	PATIENT IS RESPONSIBLE FOR AMOUNT OF THIS CLAIM/SERVICE THROUGH 'SET ASIDE ARRANGEMENT' OR OTHER AGR
202	5/6/2020	12/31/2299	NON-COVERED PERSONAL COMFORT OR CONVENIENCE SERVICES. THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE
204	5/6/2020	12/31/2299	PATIENT'S CURRENT BENEFIT PLAN.

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211	5/6/2020	12/31/2299	NATIONAL DRUG CODES (NDC) NOT ELIGIBLE FOR REBATE, ARE NOT COVERED.
214	5/6/2020	12/31/2299	WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE
215	5/6/2020	12/31/2299	BASED ON SUBROGATION OF A THIRD PARTY SETTLEMENT.
219	5/6/2020	12/31/2299	BASED ON EXTENT OF INJURY.
222	5/6/2020	12/31/2299	EXCEEDS THE CONTRACTED MAXIMUM NUMBER OF HOURS/DAYS/UNITS BY THIS PROVIDER FOR THIS PERIOD. THIS IS
223	5/6/2020	12/31/2299	ADJUSTMENT CODE FOR MANDATED FEDERAL, STATE OR LOCAL LAW/REGULATION THAT IS NOT ALREADY COVERED BY A
246	5/6/2020	12/31/2299	THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
256	5/6/2020	12/31/2299	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT.
26	5/6/2020	12/31/2299	EXPENSES INCURRED PRIOR TO COVERAGE.
27	5/6/2020	12/31/2299	EXPENSES INCURRED AFTER COVERAGE TERMINATED.
273	5/6/2020	12/31/2299	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED.
274	5/6/2020	12/31/2299	FEE/SERVICE NOT PAYABLE PER PATIENT CARE COORDINATION ARRANGEMENT.
276	5/6/2020	12/31/2299	SERVICES DENIED BY THE PRIOR PAYER(S) ARE NOT COVERED BY THIS PAYER.
289	5/6/2020	12/31/2299	SERVICES CONSIDERED UNDER THE DENTAL AND MEDICAL PLANS, BENEFITS NOT AVAILABLE.
29	5/6/2020	12/31/2299	THE TIME LIMIT FOR FILING HAS EXPIRED.
299	5/6/2020	12/31/2299	THE BILLING PROVIDER IS NOT ELIGIBLE TO RECEIVE PAYMENT FOR THE SERVICE BILLED.
31	5/6/2020	12/31/2299	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
32	5/6/2020	12/31/2299	OUR RECORDS INDICATE THE PATIENT IS NOT AN ELIGIBLE DEPENDENT.
33	5/6/2020	12/31/2299	INSURED HAS NO DEPENDENT COVERAGE.
34	5/6/2020	12/31/2299	INSURED HAS NO COVERAGE FOR NEWBORNS.
35	5/6/2020	12/31/2299	LIFETIME BENEFIT MAXIMUM HAS BEEN REACHED.
40	5/6/2020	12/31/2299	CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY/URGENT CARE. USAGE: REFER TO THE 835 HEALTHCARE POLICY
50	5/6/2020	12/31/2299	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE:
54	5/6/2020	12/31/2299	MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE. USAGE: REFER TO THE 835 HEALTHCARE POLICY
55	5/6/2020	12/31/2299	PROCEDURE/TREATMENT/DRUG IS DEEMED EXPERIMENTAL/INVESTIGATIONAL BY THE PAYER. USAGE: REFER TO THE 83
56	5/6/2020	12/31/2299	PROCEDURE/TREATMENT HAS NOT BEEN DEEMED 'PROVEN TO BE EFFECTIVE' BY THE PAYER. USAGE: REFER TO THE 8

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59	5/6/2020	12/31/2299	PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR A DAY OUTLIER AMOUNT.
60	5/6/2020	12/31/2299	NON-COVERED DAYS/ROOM CHARGE ADJUSTMENT.
69	5/6/2020	12/31/2299	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCP CLAIM/SERVICE DENIED.
78	5/6/2020	12/31/2299	MEDICARE CLAIM PPS CAPITAL COST OUTLIER AMOUNT. PRIOR HOSPITALIZATION OR 30 DAY TRANSFER REQUIREMENT NOT MET.
96	5/6/2020	12/31/2299	NON-COVERED VISITS. ONLY ONE VISIT OR CONSULTATION PER PHYSICIAN PER DAY IS COVERED.
A1	5/6/2020	12/31/2299	LATE FILING PENALTY.
A5	5/6/2020	12/31/2299	NOT A WORK RELATED INJURY/ILLNESS AND THUS NOT THE LIABILITY
A6	5/6/2020	12/31/2299	NOT A WORK RELATED INJURY/ILLNESS AND T
B1	5/6/2020	12/31/2299	WORKERS' COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVI
B14	5/6/2020	12/31/2299	
B4	5/6/2020	12/31/2299	
P2	5/6/2020	12/31/2299	
P4	5/6/2020	12/31/2299	