1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G1	Provider's charge exceeds fee schedule allowance.	The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.		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).		
G2	The OMFS does not include a code for the billed service.	The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.	Indicate code for comparable service.	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).	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
G3	The OMFS does not list the code for the billed service	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.		220	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.		
G4	Billed charges exceed amount identified in your contract.	This charge was adjusted to comply with the rate and rules of the contract indicated.	Requires name of specific Contractual agreement from which the re-imbursement rate and/or payment rules were derived.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		
G5	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the attached letter.	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.	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	M118	Alert: Letter to follow containing further information

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GENERAL							
G6	Provider charges for service that has no value.	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.		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).	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
G7	Provider bills for a service included within the value of another.	No separate payment was made because the value of the service is included within the value of another service performed on the same day.	Requires identification of the specific payment policy or rules applied. For example: CPT coding guidelines, CCI Edits, fee schedule ground rules.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
G8	Provider billed for a separate procedure that is included in the total service rendered.	A charge was made for a "separate procedure" that does not meet the criteria for separate payment. See Physician's Fee Schedule General Instructions for Separate Procedures rule.		97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
G9	Provider submitted bill with no supporting or lack of sufficient identification or documentation for the unlisted or BR Service reported.	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		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.)	N350	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.]
G10	Bill is submitted without necessary documentation needed for bill processing.	We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.	Identify documentation or report necessary for bill processing.	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.)	N29	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)]

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G11				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.)	M30	Missing pathology report.
G12				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.)	N236	Incomplete/invalid pathology report.
G13				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.)	N240	Incomplete/invalid radiology report.
G14				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.)	M31	Missing radiology report.
G15				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.)	N451	Missing Admission Summary Report.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G16				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.)	N452	Incomplete/Invalid Admission Summary Report.
G17			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.	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.)	M118	Alert: Letter to follow containing further information
G18				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.)	N456	Incomplete/Invalid Physician Order.
G19				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.)	N455	Missing Physician Order.
G20				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.)	N497	Missing Medical Permanent Impairment or Disability Report
G21				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.)	N498	Incomplete/Invalid Medical Permanent Impairment or Disability Report
G22				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.)	N499	Missing Medical Legal Report

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G23				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.)	N500	Incomplete/Invalid Medical Legal Report
G24				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.)	N501	Missing Vocational Report
G25				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.)	N502	Incomplete/Invalid Vocational Report
G26				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.)	N503	Missing Work Status Report
G27				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.)	N504	Incomplete/Invalid Work Status Report
G28				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.)	N453	Missing Consultation Report
G29				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.)	N454	Incomplete/Invalid Consultation Report
G30				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.)	N26	Missing Itemized Bill/ Statement

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G31				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.)	N455	Missing Physician's Report- Delete Comments
G32				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.)	N456	Incomplete/Invalid Physician Report
G33				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.)	N394	Incomplete/invalid progress notes/ report.
G34				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.)	N393	Missing progress notes/report.
G35				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.)	N396	Incomplete/invalid laboratory report.
G36				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.)	N395	Missing laboratory report.
G37				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.)	N458	Incomplete/Invalid Diagnostic Report.
G38				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.)	N457	Missing Diagnostic Report.

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G39				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.)	N460	Incomplete/Invalid Discharge Summary.
G40				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.)	N459	Missing Discharge Summary.
G41				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.)	N462	Incomplete/Invalid Nursing Notes.
G42				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.)	N461	Missing Nursing Notes.
G43				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.)	N464	Incomplete/Invalid support data for claim.
G44				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.)	N463	Missing support data for claim.
G45				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.)	N466	Incomplete/Invalid Physical Therapy Notes.

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G46				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.)	N465	Missing Physical Therapy Notes.
G47				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.)	N468	Incomplete/Invalid Report of Tests and Analysis Report.

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G48				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.)	N467	Missing Report of Tests and Analysis Report.
G49				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.)	N493	Missing Doctor First Report of Injury
G50				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.)	N494	Incomplete/invalid Doctor First Report of Injury.
G51				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.)	N495	Missing Supplemental Medical Report
G52				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.)	N496	Incomplete/invalid Supplemental Medical Report.

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G53				175	Prescription is incomplete	N378	Missing/incomplete/invalid prescription quantity
				176	Prescription is not current	N388	Missing/incomplete/invalid prescription number
					CARC 175 and 176 may be used with any of the listed RARC Codes	N349	The administration method and drug must be reported to adjudicate this service.
						N389	Duplicate prescription number submitted.
						M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
G54	Provider's documentation and/or code does not support level of service billed	The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.	Indicate alternate OMFS code on which payment amount is based.	150	Payer deems the information submitted does not support this level of service.	N22	This procedure code was added/ changed because it more accurately describes the services rendered.
G55	Provider bills for service that is not related to the diagnosis.	This service appears to be unrelated to the patient's diagnosis.		11	The diagnosis is inconsistent with the procedure.		
G56	Provider bills a duplicate charge.	This 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.	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).	18	Duplicate claim/service.		
G57	Service or procedure requires prior authorization and none was identified.	This service requires prior authorization and none was identified.		197	Precertification/authorization/notification absent.		
G58	Provider bills separately for report included as part of another service.	Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted.	Message shall not be used to deny separately reimbursable special and/or duplicate reports requested by the payer.	97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.

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GENERAL							
G59	Provider bills inappropriate modifier code.	The appended modifier code is not appropriate with the service billed.	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	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		

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DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
GENERAL							
G60	Billing is for a service unrelated to the work illness or injury.	Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury.		191	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)		
G61	Provider did not document the service that was performed.	The charge was denied as the report / documentation does not indicate that the service was performed.		112	Service not furnished directly to the patient and/or not documented.		
G62	Provider inappropriately billed for emergency services.	Reimbursement was made for a follow-up visit, as the documentation did not reflect an emergency.	For use in cases where the emergency physician directs the patient to return to the emergency department for non-emergent follow-up medical treatment.	40	Charges do not meet qualifications for emergent/urgent care.		
G63	Provider bills for services outside his/her scope of practice.	The billed service falls outside your scope of practice.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
G64	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Indicate name of other provider who received global payment.	134	Technical fees removed from charges.		

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GENERAL							
G65	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Provider charge of professional and/or technical component is submitted after global payment made to another provider.	Indicate name of other provider who received global payment.	89	Professional fees removed from charges.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
G66	Timed code is billed without documentation.	Documentation of the time spent performing this service is needed for further review.		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.)	N443	Missing/incomplete/invalid total time or begin/end time.
G67	Charge is for a different amount than what was pre-negotiated.	Payment based on individual pre-negotiated agreement for this specific service.	Identify name of specific contracting entity, authorization # if provided, and pre- negotiated fee or terms. This EOR is for individually negotiated items/	131	Claim specific negotiated discount.		
G68	Charge submitted for service in excess of pre-authorization.	Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original authorization.		198	Precertification/authorization exceeded.	N435	Exceeds number/frequency approved /allowed within time period without supporting documentation.
G69	Charge is made by provider outside of HCO or MPN.	Payment is denied as the service was provided outside the designated Network.	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.	38	Services not provided or authorized by designated (network/primary care) providers.		
G70	Charge denied during Prospective or Concurrent Utilization Review	This charge is denied as the service was not authorized during the Utilization Review process. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	39	Services denied at the time authorization/pre-certification was requested.	N175	Missing review organization approval.

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GENERAL							
G71	Charge denied during a Retrospective Utilization Review.	This charge was denied as part of a Retrospective Review. If you disagree, please contact our Utilization Review Unit.	Optional: Provide Utilization Review phone number.	216	Based on the findings of a review organization		
G72	Charge being submitted for Retrospective Review	This charge is being sent to Retrospective Review as there is no indication that prior authorization has been sought.		15	The authorization number is missing, invalid, or does not apply to the billed service	N175	Missing review organization approval
G73	Provider bills with missing, invalid or inappropriate authorization number	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		15	The authorization number is missing, invalid, or does not apply to the billed service.		
G74	Provider bills and does not provide requested documentation or the documentation was insufficient or incomplete	Requested documentation to support the bill was absent or incomplete.	Identify the necessary items.	226	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.)	N66	Missing/incomplete/invalid documentation.
G75	Provider bills payer/employer when there is no claim on file	Bill payment denied as the patient cannot be identified as having a claim against this claims administrator.		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.)	MA61	Missing/in-complete/invalid social security number or health insurance claim number.
G76	Provider bills for services that are not medically necessary	These are non-covered services because this is not deemed a 'medical necessity' by the payer.		50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.		
G77	Provider submits bill to incorrect payer/contactor	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		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.		

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GENERAL							
G78	Provider bills for multiple services with no or inadequate information to support this many services.	Payment adjusted because the payer deems the information submitted does not support this many services.		151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.		
G79	Bill exceeds or is received after $10,000 cap has been reached on a delayed claim	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.	.	119	Benefit maximum for this time period or occurrence has been reached.	N436	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.
G80	Bill is submitted that is for a greater amount than remains in the $10,000 cap.	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.		119	Benefit maximum for this time period or occurrence has been reached.	N437	Alert: If the injury claim is accepted, these charges will be reconsidered.
G81	Payer is paying self-executing penalties and interest to the provider due to late payment.	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	Add 15% penalty and appropriate interest to the payment.	225	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.		

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PHYSICAL MEDICINE							
PM1	Non-RPT provider bills Physical Therapy Assessment and Evaluation code.	This charge was denied as the Physical Therapy Assessment and Evaluation codes are billable by Registered Physical Therapists only.		8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
PM2	Provider bills both E/M or A/E, and test and measurement codes on the same day.	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).		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.)	N435	Exceeds number/ frequency approved /allowed within time period without support documentation.
PM3	Provider bills three or more modalities only, in same visit.	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.		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
PM4	Provider bills “additional 15 minute” code without billing the “initial 30 minute” base code.	This physical medicine extended time service was billed without the “initial 30 minutes” base code.		107	The related or qualifying claim/ service was not identified on this claim.	N122	Add-on code cannot be billed by itself.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHYSICAL MEDICINE							
PM5	Provider bills a second physical therapy A/E within 30 days of the last evaluation.	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)		119	Benefit maximum for this time period or occurrence has been reached.	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
PM6	Provider billing exceeds 60 minutes of physical medicine or acupuncture services.	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).		119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
PM7	Provider bills more than four physical medicine procedures and/or chiropractic manipulation and/or acupuncture codes during the same visit without prior authorization.	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).		151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHYSICAL MEDICINE							
PM8	Provider bills full value for services subject to the multiple service cascade.	Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.		59	Processed based on multiple or concurrent procedure rules.		
PM9	Provider bills office visit in addition to physical medicine/acupuncture code or OMT/CMT code at same visit. Specified special circumstances not applicable.	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).		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
PM10	Provider fails to note justification for follow-up E/M charge during treatment.	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).		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).	N435	Exceeds number/frequency approved /allowed within time period without support documentation.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHYSICAL MEDICINE							
PM11	Physical Therapist charged for E/M codes which are limited to physicians, nurse practitioners, and physician assistants.	Charge was denied as Physical Therapists may not bill Evaluation and Management services.		170	Payment is denied when performed/billed by this type of provider.		
PM12	Pre-surgical visits in excess of 24 are charged without prior authorization for additional visits.	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.	Optional: Provide Utilization Review phone number.	198	Precertification/authorization exceeded.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S1	Physician billing exceeds fee schedule guidelines for multiple surgical services.	Recommended payment reflects Physician Fee Schedule Surgery Section, rule 7 guidelines for multiple or bi-lateral surgical services.		59	Processed based on multiple or concurrent procedure rules.		
S2	Physician billed for initial casting service included in value of fracture or dislocation reduction allowed on the same day.	The value of the initial casting service is included within the value of a fracture or dislocation reduction service.		97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
S3	Physician bills office visit or service which is not separately reimbursable as it is within the global surgical period.	The visit or service billed, occurred within the global surgical period and is not separately reimbursable.		97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
S4	Multiple arthroscopic services to same joint same session are billed at full value.	Additional arthroscopic services were reduced to 10 percent of scheduled values pursuant to Surgery Section, rule 7 re: Arthroscopic Services.		59	Processed based on multiple or concurrent procedure rules.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S5	Physician bills initial visit in addition to starred service, which constituted the major service.	This initial visit was converted to code 99025 in accordance with the starred service Surgery Section, rule 10 (b) (1).		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).	N22	This procedure code was added/changed because it more accurately describes the services rendered.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S6	Assistant Surgeon charged greater than 20% of the surgical procedure.	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).		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 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).	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S7	Non-physician assistant charged greater than 10% of the surgical procedure.	Non-physician assistant surgeon has been reimbursed at 10% of the surgical procedure. (See Modifier 83 in the Surgery Section of the Physician's Fee Schedule).		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).	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
S8	Surgeon's bill does not include operative report	The surgeon's bill has been rejected as we have not received the operative report. Resubmit bill with the operative report for reconsideration.		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.)	M29	Missing operative note/report.
S9	Operative Report does not cite the billed procedure.	Incomplete/invalid operative report (billed service is not identified in the Operative Report)		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.)	N233	Incomplete/ invalid operative report.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SURGERY							
S10	Surgeon's bill includes separate charge for delivery of local anesthetic.	Administration of Local Anesthetic is included in the Surgical Service per Surgery Section, rule 16.		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 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	N514	Consult plan benefit documents/guidelines for information about restrictions for this service.
S11	Procedure does not normally require an Assistant surgeon or multiple surgeons and no documentation was provided to substantiate a need in this case.	Assistant surgeon services have been denied as not normally warranted for this procedure according to the listed citation.	Identify the reference source listing of approved Assistant Surgeon services.	54	Multiple physicians/ assistants are not covered in this case.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
ANESTHESIA							
A1	Physician bills for additional anesthesia time units not allowed by schedule	Modifier -47 was used to indicate regional anesthesia by the surgeon. In accordance with the Physician Fee Schedule, time units are not reimbursed.		97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
A2	No anesthesia records provided for payment determination.	Please submit anesthesia records for further review.		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.)	N463	Missing support data for claim.
A3	Insufficient information provided for payment determination.	Please submit complete/valid anesthesia records for further review.		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.)	N464	Incomplete/invalid support data for claim.
A4	Insufficient information provided for payment determination.	Please submit anesthesia records time units for further review.		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.)	N203	Missing/incomplete/invalid anesthesia time/units

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
ANESTHESIA							
A5	Documentation does not describe emergency status.	Qualifying circumstances for emergency status not established.		40	Charges do not meet qualifications for emergent/urgent care.		
A6	Documentation does not describe physical status/condition.	Patient's physical status/condition not identified. Please provide documentation using ASA Physical Status indicators.		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.)	N439 N440	Missing anesthesia physical status report/indicators. Incomplete/invalid anesthesia physical status report/indicators.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
E/M							
EM1	Physician bills for office visit which is already included in a service performed on the same day.	No reimbursement was made for the E/M service as the documentation does not support a separate significant, identifiable E&M service performed with other services provided on the same day.	This EOR should only be used if documentation does not support the use of modifier 25, 57, or 59.	95	Plan procedures not followed.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
EM2	Documentation does not support Consultation code.	The billed service does not meet the requirements of a Consultation (See the General Information and Instructions Section of the Physician's Fee Schedule).		150	Payer deems the information submitted does not support this level of service.	N130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.
EM3	Documentation does not support billing for Prolonged Services code.	Documentation provided does not justify payment for a Prolonged Evaluation and Management service.		152	Payer deems the information submitted does not support this length of service.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
CLINICAL LAB							
CL1	Physician bills for individual service normally part of a panel.	This service is normally part of a panel and is reimbursed under the appropriate panel code.		97	The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
PHARMACY							
P1	Charge for Brand Name was submitted without “No Substitution” documentation.	Payment was made for a generic equivalent as “No Substitution” documentation was absent.		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).	N447	Payment is based on a generic equivalent as required documentation was not provided.
P2	Provider charges a dispensing fee for over-the-counter medication or medication administered at the time of the visit	A dispensing fee is not applicable for over-the-counter medication or medication administered at the time of a visit		91	Dispensing fee adjustment.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
DME							
DME1	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N446	Incomplete/invalid document for actual cost or paid amount.
DME2	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		108	Rent/purchase guidelines were not met.	N445	Missing document for actual cost or paid amount.
DME3	Billing for purchase is received after cost of unit was paid through rental charges.	Charge is denied as total rental cost of DME has met or exceeded the purchase price of the unit		108	Rent/purchase guidelines were not met.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
DME							
DME4	Billed amount exceeds formula using documented actual cost for DMEPOS	Payment for this item was based on the documented actual cost.		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).		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SPECIAL SERVICES							
SS1	A physician, other than the Primary Treating Physician or designee submits a Progress and or Permanent and Stationary Report for reimbursement.	The Progress report and or Permanent and Stationary Report were disallowed as you are not the Primary Treating Physician or his/her designee.		B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N450	Covered only when performed by the primary treating physician or the designee.
SS2	Non-reimbursable report is billed.	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.		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).	N390	This service/report cannot be billed separately.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
SPECIAL SERVICES							
SS3	No request was made for Chart Notes or Duplicate Report.	Chart Notes/Duplicate Reports were not requested.		96	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.)	N390	This service/report cannot be billed separately.
SS4	Missed appointment is billed.	No payment is being made, as none is necessarily owed		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).	N441	This missed appointment is not covered.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
F1	Procedure is on the Inpatient Only list. Needs advanced authorization in order to be performed on an outpatient basis.	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.		197	Precertification/ authorization/ notification absent.		
F2	Charge submitted for facility treatment room for non-emergent service.	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.		40	Charges do not meet qualifications for emergent/urgent care.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
F3	Paid under a different fee schedule.	Service not reimbursable under Outpatient Facility Fee Schedule. Charges are being paid under a different fee schedule.	Specify which other fee schedule.	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).	N442	Payment based on an alternate fee schedule.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
F4	No payment required under Outpatient Facility Fee Schedule	Service not paid under Outpatient Facility Fee Schedule.		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).	130	Alert: Consult plan benefit documents/ guidelines for information about restrictions for this service.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
F5	Billing submitted without HCPCS codes	In accordance with OPPS guidelines billing requires HCPCS coding.		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).	M20	Missing/incomplete/invalid HCPCS.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
FACILITY							
F6	Facility has not filed for High Cost Outlier reimbursement formula.	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.		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).	N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
MISC.							
M1	Bill submitted for non compensable claim	Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/ treatment.		214	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.		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
MISC.							
M2	Appeal /Reconsideration	No additional reimbursement allowed after review of appeal/reconsideration.		193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.		
M3	Third Party Subrogation	Reduction/denial based on subrogation of a third party settlement.		215	Based on subrogation of a third party settlement.		
M4	Claim is under investigation	Extent of injury not finally adjudicated. Claim is under investigation.		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).		

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
MISC.							
M5	Medical Necessity Denial. You may submit a request for an appeal/reconsideration.	Medical Necessity Denial. You may submit a request for an appeal/reconsideration.		50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.		
M6	Appeal/ Reconsideration denied based on medical necessity.			50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
M7	This claim is the responsibility of the employer. Please submit directly to employer.			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

DWC Bill Adjustment Reason Code	CARC	RARC
G59	4	
G63	8	
PM1	8	
G55	11	
G72	15	N175
G73	15	
G9	16	N350
G10	16	N29
G11	16	M30
G12	16	N236
G13	16	N240
G14	16	M31
G15	16	N451
G16	16	N452
G17	16	M118
G18	16	N456
G19	16	N455
G20	16	N497
G21	16	N498
G22	16	N499
G23	16	N500
G24	16	N501
G25	16	N502
G26	16	N503
G27	16	N504
G28	16	N453
G29	16	N454
G30	16	N26
G31	16	N455
G32	16	N456
G33	16	N394
G34	16	N393
G35	16	N396
G36	16	N395
G37	16	N458
G38	16	N457
G39	16	N460
G40	16	N459

2.0 Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
G41	16	N462
G42	16	N461
G43	16	N464
G44	16	N463
G45	16	N466
G46	16	N465
G47	16	N468
G48	16	N467
G49	16	N493
G50	16	N494
G51	16	N495
G52	16	N496
G66	16	N443
PM2	16	N435
S8	16	M29
S9	16	N233
A2	16	N463
A3	16	N464
A4	16	N203
A6	16	N439 N440
G56	18	
G75	31	
G69	38	
G70	39	N175
G62	40	
A5	40	
F2	40	
G4	45	
G76	50	
M5	50	
M6	50	N10
S11	54	N130
PM8	59	
PM9	59	N130
S1	59	
S4	59	N130
G65	89	N130

2.0 Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
P2	91	
EM1	95	M15
SS3	96	N390
G7	97	
G8	97	M15
G58	97	N390
S2	97	
S3	97	M144
A1	97	N130
CL1	97	M15
PM4	107	N122
DME1	108	N446
DME2	108	N445
DME3	108	
G77	109	
M7	109	
G61	112	
G79	119	N436
G80	119	N437
PM3	119	N362
PM5	119	N130
PM6	119	N362
G67	131	
G64	134	
G54	150	N22
EM2	150	N130
G78	151	
PM7	151	N362
EM3	152	
G5	162	M118
PM11	170	
G53	175 176	N378 N388 N349 N389 M123
G60	191	
M2	193	

2.0 Matrix List in CARC Order

DWC Bill Adjustment Reason Code	CARC	RARC
G57	197	
F1	197	
G68	198	N435
PM12	198	
M1	214	
M3	215	
G71	216	
G3	220	
M4	221	
G81	225	
G74	226	N66
SS1	B7	N450
G1	W1	
G2	W1	N448
G6	W1	N130
PM10	W1	N435
S5	W1	N22
S6	W1	N130
S7	W1	N130
S10	W1	N514
P1	W1	N447
DME4	W1	
SS2	W1	N390
SS4	W1	N441
F3	W1	N442
F4	W1	130
F5	W1	M20
F6	W1	N444