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Alaska Medicaid Provider Update

Remittance Advice Code and Denial Reason List
July 31, 2023

Optum uses the national codes for claim adjustment and remittance advice reason codes. The link to the national codes is: External Code Lists | X12. In addition, this update contains the Optum claim codes and reasons.

Facets Code	CARC Code	RARC Code	Short Description	Long Description	Liability
002			Increased allowable	Increased allowable	N/A
003			Reduced allowable	Reduced allowable	N/A
017			Increased allowable units	Increased allowable units	N/A
018			Reduced allowable units	Reduced allowable units	N/A
073			Deny All Claim Lines	Deny All Claim Lines	N/A
346	18	0	Duplicate	Duplicate	Provider
AK6	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
AKT	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
B01	11	0	Invalid Diagnosis/CPT Combination	This is an invalid diagnosis code and procedure code combination.	Provider
B02	96	N130	Service Not Covered for this Provider	This service is not covered for this provider under your plan.	Member
B05	96	N130	Your plan does not cover this expense	Your Behavioral Health Plan does not cover this expense.	Member
B08	5	M77	Place of service inappropriate for procedure	This place of service is inappropriate for this service.	Provider
B14	109	N418	Please forward to correct carrier	Medical Services not covered under Behavioral Health coverage. Please submit claim to your Medical Health Plan for processing.	Provider
B37	96	N130	OON provider services not covered for plan	Your plan does not cover services you received from a non-network provider.	Member
B44	234	M15	Add-on is not payable	Add-on not payable when primary is not payable. Review primary denial.	Notification
B45	181	N56	This is not a reimbursable service.	This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service.	Provider
B46	182	517	Invalid Procedure Modifier Combination	Invalid procedure modifier combination.	Provider
B47	6	N129	Inconsistent with patient's age	The submitted procedure is disallowed because it is inconsistent with the patient's age.	Provider
B62	16	N77	Individual provider name, license req	Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.	Provider

B70	96	N30	No benefit plan exists	No benefit plan exists	Member
B71	258	N103	Participant Incarcerated	Participant Incarcerated on DOS	Member
B72	96	N30	Medicare Premium Only	Medicare Premium Only	Provider
B77	109	N418	Please forward to correct carrier	Medical Services not covered under Behavioral Health coverage.	Member
B88	97	N19	Services included in facility payment	After review, it was determined this service was included in the payment of the facility	N/A
CD0	119	N362	Exceeds Clinical Review Criteria	This session has exceeded the clinical review criteria. You can obtain medical necessity review upon appeal.	Provider
CDD	18	N522	Definite Duplicate Claim	This claim is a duplicate of a previously submitted claim for this member.	N/A
DNA	243	N130	Deny due to No Authorization	Deny due to No Authorization	Provider
EA1			Contraindicated Service	Contraindicated Service	Provider
EEA	96	N95	AK- Lock in Program	Alaska Lock in Program	Provider
E14	109	N418	Please forward to correct carrier	These services are not covered under this plan. Please forward this explanation of benefits & the bill to your Medical Insurance Carrier.	Provider
E40	96	N161	Professional fees can't be Processed w/o hospital bill	We will process this charge when we receive the hospital bill and records.	N/A
FBM	163	N706	TPL Indicated No Resource on File	TPL Indicated on Claim Form - No Resource on State File	Provider
FD1	146	N517	Submit Active Diagnosis for DOS	Submit Active Diagnosis for DOS.	Provider
FEA	96	N95	AK - Lock in Program	Alaska Lock in Program	Provider
F10	252	N707	Required info not received from provider	The required information requested from the provider has not been received within 45 days. Claim has been closed; appeal must be filed.	Provider
FOD	16	N77	Individual provider name, license req	Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.	Provider
HD3	207	N257	Invalid Billing Provider NPI	Claim denied due to Invalid Billing Provider National Provider Identifier.	Provider
HD4	207	N290	Invalid Rendering Provider NPI	Claim denied due to Invalid Rendering Provider National Provider Identifier.	Provider
J01			COB Allowable Amount Override	A COB override has occurred on this claim.	NA
KD4	207	N257	Invalid billing provider ID	Deny Invalid billing NPI	Provider
L03	16	N418	Send Primary Carrier EOB for this charge	Send Primary Carrier EOB for this charge.	Notification
N29	119	N435	Exceeds Clinical Review Criteria	This session has exceeded the clinical review criteria. You can obtain medical necessity review upon appeal.	Provider
N78	16	M64	Invalid Diagnosis Code	Invalid Diagnosis Code.	Provider
PAK	45	0	Exceeds per diem rate	Exceeds per diem rate.	Notification
PS	45	0	Your plan does not cover this expense.	Your Behavioral Health Plan does not cover this expense.	Member
PSC	45	0	Exceeds the R&C Rate	Benefits are reduced because a Network Provider was not used. The Patient is responsible for any difference between the charge and paid amt.	Member

PSS	45	0	Exceeds the Scheduled Rate	Charge exceeds allowable rate for this service or code submitted is not on contracted fee schedule-contact Network Manager for correct code.	Notification
PMX	45	0	Maximum Provision	Pricing is the lesser of billed or contract allowable amount.	Provider
S1A	31	0	No eligibility found	The member's coverage was not in effect on the date the service was provided.	Member
S1C	26	N30	Plan not effective on date requested	The Member's coverage was not in effect on the date the service was provided.	Member
S20	26	N30	Date req. prior to Member Orig. Eff Date	The Member's coverage was not in effect on the date services were provided.	Member
S21	26	N30	Date req. prior to Group Effective Date	The Member's coverage was not in effect on the date services were provided.	Member
S22	26	N30	Date req. prior to subgroup original effective date.	The Member's coverage was not in effect on the date services were provided.	Member
S23	26	N	Deny req. Prior to Subscriber Eff Dt	The Member's coverage was not in effect on the date services were provided.	Member
SN	31	0	Non-eligible member	Member not eligible for benefits.	Member
SS	27	N30	Separation - Member	Termination via Member-level separation event.	Member
ST	27	N650	Termination	Member not eligible for Benefits.	Member
TF0	29	0	Submitted after plan filing limit	This claim was submitted after the claim filing limit.	Provider
TF1	29	0	Submitted After Provider's Filing Limit	Claim submitted after filing limit.	Provider
TF3	29	0	Provider COB Filing Period Exceeded	Provider Coordination of Benefits timely filing period exceeded	Provider
TMA	27	N30	Group Termination	Member not eligible.	Member
UM1	50	N362	Units exceed UM authorization	Units exceed a Utilization Management authorization.	Provider
UM2	50	N362	Units reduced by UM authorization	Units were reduced by a utilization management authorization.	Provider
V46	182	N517	Invalid Procedure Modifier Combination	Invalid Procedure Modifier Combination	Provider
W04	16	N245	Incomplete/Invalid plan in place	Deny due to proper primary payer plan not in place.	Provider
W09	251	N4	Missing/Incomplete/Invalid EOB	Missing/Incomplete/Invalid Prior Insurance Carrier(S) explanation of benefits	Member
W10	119	N362	Daily Max Limit	The billed charges exceed the daily limit maximum for services filled.	Provider
W14	109	N418	Please forward to correct carrier	These services are not covered under this plan. Please forward this explanation of benefits and the bill to your medical insurance carrier.	Provider
W19	16	M64	DX Code missing 4th or 5th digit	Missing/incomplete/invalid/other diagnosis code.	Provider
W37	96	N130	OON provider-services not covered for plan	Your plan does not cover services you received from a non-network provider.	Member
WAH	234	N20	Already allowed or not paid separately	This service was included in a service already reported or it is not paid separately.	Provider
WFC	16	N34	Correct Claim Format Required	Incorrect claim form/format for this service(s).	Provider
WPM	182	N517	Invalid Procedure Modifier Combination	Invalid Procedure Modifier Combination	Provider
Z06	243	N130	Deny due to No Authorization	Deny due to No Authorization.	Provider

Claim Adjustment Reason Codes (CARC)

RARC	RARC Description
5	The procedure code/type of bill is inconsistent with the place of service
6	The procedure/revenue code is inconsistent with the patient's age
11	The diagnosis is inconsistent with the procedure.
16	Claim/service lacks information or has submission/billing error(s).
18	Exact duplicate claim/service
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
96	Non-covered charge(s)
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
119	Benefit maximum for this time period or occurrence has been reached.
163	Attachment/other documentation referenced on the claim was not received.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
234	This procedure is not paid separately.
243	Services not authorized by network/primary care providers.

Remittance Advice Remark Coding (RARC) Codes

RARC	RARC Description
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M64	Missing/incomplete/invalid other diagnosis.
M77	Missing/incomplete/invalid/inappropriate place of service.
N129	Not eligible due to the patient's age.
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N30	Patient ineligible for this service.
N34	Incorrect claim form/format for this service
N362	The number of Days or Units of Service exceeds our acceptable maximum.
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
N418	Misrouted claim. See the payer's claim submission instructions.
N435	Exceeds number/frequency approved /allowed within time period without support documentation.
N517	Resubmit a new claim with the requested information.
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
N56	Procedure code billed is not correct/valid for the services billed, or the date of service billed.
N650	This policy was not in effect for this date of loss. No coverage is available.
N706	Missing documentation.
N77	Missing/incomplete/invalid designated provider number.
N95	This provider type/provider specialty may not bill this service