Explanation of Benefits - Adjustment Codes

Code	CBP Reason
AA	Adjustment applied per Department of Consumer and Business Services (DCBS) decision/order. Appeals must be directed to DCBS.
BA	Reimbursement made to another insurance company.
BB	Reimbursement made to the employer.
BC	Reimbursement made to the worker.
BD	Reimbursement has already been made to the rendering provider.
BE	Adjustment applied for amount the worker paid toward prescription cost.
CA	Disallowed; postoperative visit included in surgical/global fee.
CB	Disallowed; procedure is unbundled, performed in conjunction with, or included in another procedure or visit.
CC	Disallowed; preoperative evaluation related to an elective surgery is included in the global surgery fee per OAR 436-009-0040.
CD	Adjustment applied for previously allowed global (pre-op and/or post-op) service.
CF	Disallowed; fitting and adjusting is included in the orthotic/prosthetic code billed.
CG	Disallowed; supplies required for treatment or diagnostic procedure are not separately reimbursable.
CH	Disallowed; only supplies over and above those usually included with the office visit or procedure(s) rendered may be reported separately per CPT.
CI	Only one unit is allowed. Per CPT, the code is based on 15-minute time increments. Reimbursement is not based on the number of regions treated.
CJ	Per CPT Assistant, Vol. 19, Issue 12, 12/09, CPT 65435 is considered an inclusive component of corneal foreign body removal when performed on the same day. Rust ring is considered foreign to the cornea; removal is reported on either CPT 65220 or 65222.
CK	Only one unit is allowed. A rapid urine check or urine screen with a single report is reimbursable as one test even when the test provides the threshold level for multiple different components.
CL	Disallowed; when electric stimulation of any needle is used during acupuncture, 97813 or 97814 are the correct codes per CPT. Electric stimulation is not payable in addition to 97810 or 97811.
CM	Disallowed; service is included in the ASC facility fee per OAR 436-009-0023.
CN	Disallowed; surgical procedure(s) include the follow-up care per CPT Surgery Guidelines. Only complications or other conditions requiring additional services should be separately reported.
DA	Disallowed; aggravation denial issued or not perfected.
DB	Disallowed; claim denied or in litigation. Oregon Workers' Compensation law does not permit collection of medical services payment from the worker until the compensability decision is resolved.
DC	Disallowed; claim settlement has been issued.
DD	Disallowed; service appears to be unrelated to a compensable condition.
DE	Disallowed; partial denial of condition, current condition denial, or combined condition denial has been issued.
DF	Disallowed; claim denial is final. Private insurance may now be billed.
EA	Disallowed; the medical arbiter has been previously reimbursed for file review of the same records in less than 10 business days.
EB	Disallowed; only the physician who prepares and submits the report shall receive the fee for the report per DCBS billing instructions.
EC	Disallowed; communication between one healthcare provider to another healthcare provider is not reimbursable.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
ED	Disallowed; CPTs 97010-97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider per OAR 436-009-0040.
EE	Disallowed; billing has been forwarded to SAIF's Legal department for payment consideration. Contact SAIF's Legal dept. for clarification, 1-800-285-8525 ext. 8506.
EF	Disallowed; per CPT guidelines, initial care of fracture and/or dislocation should be reported on the appropriate cast, splint, strapping, and/or supply code.
EG	Disallowed; service exceeds the 30-day submission period. Per OAR 438-015-0019(3), the cost bill shall be submitted to the carrier within 30 days after the order finding that claimant prevails against a denied claim under ORS 656.386(1) becomes final.
EH	Adjustment applied to reflect the maximum allowable. Per ORS 44.415(2), witness fees are payable at $5 per day and 8 cents per mile for proceedings where a public body is a party. ORS 656.751 creates SAIF as a public corporation.
EI	Disallowed; the IME and related services were set up by the IME company. Please direct the bill and payment inquiries to the IME company.
EJ	Disallowed; a separate fee is not payable for review of the IME report. Per OAR 436-009-0070, the review and response to an IME is payable on D0019.
EK	Disallowed; the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed is a key component in determining the complexity of medical decision making.
EL	Disallowed; requested record review of less than 30 minutes total duration is not separately report/billed per CPT guidelines.
EM	Adjustment applied to reflect the maximum allowable. Per OAR 438-015-0019(2) and ORS 656.386(2)(d), Cost Bill expenses may not exceed $1,500.
EN	Disallowed; service does not qualify for reimbursement. Per OAR 438-015-0019(1) and ORS 656.386(2), Cost Bill reimbursements consist of incurred expenses and costs for records, expert opinions, and witness fees.
EO	Disallowed; completion of clinical justification form required per OAR 436-009-0090, is not reimbursable.
EP	Disallowed; prolonged service less than 30 minutes total duration on a given date is not separately reported/billed per CPT guidelines.
ER	Disallowed; a medical provider may bill for review of records if asked to review records or reports prepared by another medical provider, insurance carrier or their representative per OAR 436-009-0040(7). Review of provider's own records is not payable.
ES	Disallowed; surface EMGs are not payable per OAR 436-009-0010.
ET	Disallowed; thermography is not payable per OAR 436-009-0010.
EU	Disallowed; no description was provided. Per OAR 436-009-0010, if there is no specific code for a medical service the provider should use an appropriate unlisted code from HCPCS or CPT and provide a description of the service provided.
EX	Disallowed; x-ray copies are not reimbursable. Per OAR 436-010-0230, a reasonable charge may be made for the delivery costs of diagnostic studies, including films. The insurer must return the films to the medical provider.
EY	Disallowed; separate reading of x-rays by the physician are not reimbursable when those x-rays are interpreted and billed by another physician or radiologist. Only one reimbursement can be made for the interpretation of x-rays.
FA	Disallowed; NDC required for pharmaceutical service per OAR 436-009-0090 and OAR 436-009-0010 is missing or invalid.
FB	Adjustment applied for no-show or late cancel. Per OAR 436-009-0015, no fee is payable for a missed appointment except a closing exam or an appointment arranged by the insurer.
FC	Adjustment applied for physician assistant or nurse practitioner fees per OAR 436-009-0010(6).
FD	Disallowed; bill not submitted within 12 months of the date of service or 60 days of receiving knowledge of the responsible insurer is not payable except as specified in OAR 436-009-0010 and 436-009-0110.
FE	Disallowed; report, form, or chart note copies are required per OARs 436-009-0010 & 436-009-0090.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
FF	Disallowed; service code is missing, incorrect, or invalid per CPT, CDT, HCPCS, NDC or Oregon Administrative Rules.
FG	Adjustment applied to DME or implant per OAR 436-009-0023.
FH	Adjustment applied to reflect multiple studies done within two days, per OAR 436-009-0040.
FI	Adjustment applied to reflect the fee schedule for rendering surgical or post-operative care only.
FJ	Disallowed; service exceeds physical medicine 3-code daily maximum per OAR 436-009-0040(6).
FL	Multiple procedures performed at the same operative session. Allowances made at 100%, 50% per OAR 436-009-0040(3) and ASC's allowances made per multiple procedure/contract per OAR 436-009-0023.
FM	Co-surgeons/two surgeons; 25% reduction per OAR 436-009-0040 or per provider's billing agreement.
FN	Disallowed; worker reimbursement exceeds two years and is not timely per OAR 436-009-0025.
FO	Adjustment applied for MD surgical assistant to 20% of primary surgeon's payment per OAR 436-009-0040.
FP	Adjustment applied for physician assistant or nurse practitioner surgical assistance per OAR 436-009-0040.
FQ	Adjustment applied for other self-employed surgical assistant working under direct control and supervision of a physician to 10% of primary surgeon's payment per OAR 436-009-0040.
FR	Disallowed; documentation does not support the report of findings. Per OAR 436-009-0040, x-ray films must include a report of the findings in order to be paid.
FS	Disallowed; HCPCS codes are required per OAR 436-009-0010.
FT	Fee schedule applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9).
FV	Disallowed; documentation does not support the emergency basis and interruption of the daily schedule. CPT 99058 is allowable when the services are provided on an emergency basis and the daily schedule is disrupted in order to treat the worker.
FW	Disallowed; required documentation supporting the service/item billed is not attached per Oregon Administrative Rules. Billing must be resubmitted with supporting documentation.
FX	Adjustment applied to reflect Hospital cost-charge ratio/fee schedule per OAR 436-009-0020.
FY	Disallowed; documentation does not support a separately identifiable E/M service, above and beyond the usual preservice work associated with the acupuncture or manipulation service.
FZ	Disallowed; ASC's implant cost required per 436-009-0023.
GA	Disallowed; invoice does not include the total amount of time spent interpreting per OAR 436-009-0110.
GB	Disallowed; invoice does not include the name and/or address of the medical provider per OAR 436-009-0110.
GC	Disallowed; invoice does not include the name of the interpreter per OAR 436-009-0110.
GD	Disallowed; interpreter mileage cannot be verifed. Starting address is needed per OARs 436-009-0110.
GE	Disallowed; total interpreter time cannot be verified. Allowance is made for one hour. Per OAR 436-009-0110(7)(g), SAIF is requesting start and end times to determine reimbursement of additional time.
GF	Disallowed; prescriptions for more than a 5-day supply of Celebrex, Cymbalta, Fentora, Kadian, Lidoderm, Lyrica, or OxyContin require the prescribing physician to submit a Form 4909 per OAR 436-009-0090.
GG	Disallowed; documentation does not support 3-D imaging was rendered. Per CPT, 2-D reformatting is not a separately reportable service.
GH	Disallowed; documentation does not support post-processing of 3-D rendering on an independent workstation.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
GI	Disallowed; documentation does not support an independent trained observer was present to monitor the patient's level of consciousness and physiological status.
GJ	Disallowed; this service generally requires not less than two hours of actual patient contact per OAR 436-009-0070. Documentation does not identify the total evaluation time.
GK	Disallowed; this service generally requires not less than four hours of actual patient contact per OAR 436-009-0070. Documentation does not identify the total evaluation time.
GM	Disallowed; documentation does not include the specific measurements. Per CPT, testing performed without recording specific measurements or that does not include a separate report, should not be billed.
GN	Disallowed; report of laboratory findings is required.
GO	Adjustment applied per OAR 436-009-0110 to reflect treatment time documented by the medical provider. Clarification of additional interpreter time is needed.
GP	Disallowed; documentation does not indicate the face-to-face psychotherapy time.
GQ	Disallowed; documentation does not support a prolonged physician service was performed. The documentation does not contain the total time spent with direct (face-to-face) patient contact.
GR	Disallowed; time spent reviewing the records or reports is not documented per OAR 436-009-0040.
GS	Disallowed; missing or invalid MS-DRG code billed. The MS-DRG is required per OAR 436-009-0020.
GT	Disallowed; documentation does not support testing of additional body regions. Per CPT, it is appropriate to bill one unit per body region. The audit reflects only one unit.
GU	Disallowed; documenation does not clearly identify regions treated.
GV	Disallowed; each chart note entry must identify the provider of service per OAR 811-015-0005.
GW	Disallowed; invalid/missing ICD-CM principal, admit, patient reason, or other ICD-CM code. OAR 436-009 requires ICD-10 codes for dates of service effective 10/1/15 and ICD-9 codes for dates prior to 10/1/15.
GX	Disallowed; missing prescriber name/NPI, date rx written, or U & C charge. Invalid or missing compound indicator. Completed NCPDP form required per OAR 436-009-0010.
GY	Disallowed; invalid/missing admit code. Required per OAR 436-009-0010.
IA	Disallowed; the person providing the interpreter services does not qualify for reimbursement per OARs 436-009-0005 and 436-009-0110.
IB	Adjustment applied to reflect appropriate allowance per OAR 436-009-0110.
IC	Disallowed; distance traveled by interpreter does not qualify for reimbursement per OARs 436-009-0110.
ID	Disallowed; interpreter service does not qualify for reimbursement. Per OAR 436-009-0005, interpreter services means the act of orally translating between a medical provider and a patient.
IE	Disallowed; charge is not payable. Per OARs 436-009-0110, only interpreter services and mileage are reimbursable.
IF	Disallowed; an interpreter may only bill an insurer per OARs 436-009-0110. Interpreter billings submitted by medical providers are not payable.
IG	Adjustment applied to reflect overlapping appointment times by the same interpreter. Reimbursement for interpreter services is not payable more than once for the same time period.
IH	Disallowed; physician certification of the patient's home health plan is not required for workers' compensation and was not requested.
II	Disallowed; service must be billed on appropriate Oregon Specific Code per OAR 436-009-0060.
IJ	Adjustment is applied to reflect total interpreter time for consecutive appointments by the same interpreter.
IK	Disallowed; interpreter service related to medical service by a non-MCO provider. Per OAR 436-009-0010, the worker may be held responsible for payment.
IM	Disallowed; provider must be CARF or JCAHO accredited for reimbursement on multidisciplinary service codes per OAR 436-009-0060.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
IN	Disallowed; services are not payable under ORS 656.313 and OAR 436-060-0190 which specifies circumstances for health insurance reimbursement.
IP	Disallowed; reimbursement cannot be issued until the requested service has been rendered. Insurers must pay the lesser of the fee schedule or the provider¿s usual fee per OAR 436-009-0040.
IS	Disallowed; equipment directly related to the provision of the surgical procedure is included in the ASC facility fee per OAR 436-009-0023.
IT	Disallowed; drug/alcohol testing is not payable. The service may be payable by the employer.
IU	Disallowed; treatment time less than 8 minutes is not payable for a time based physical medicine code per OAR 436-009-0040.
IV	Adjustment is applied to reflect 50% reduction per anesthesia modifier QK, QX, or QY.
MA	Adjustment applied for MCO contract package price.
MC	Adjustment applied to reflect MCO contract rate or discount. Direct inquiries/appeals to the MCO.
MD	Disallowed; audited to MCO guidelines/certification/contract or unable to verify certification of services. Direct inquiries/appeals to the MCO.
ME	Disallowed; service not payable per SAIF/MCO contract. Direct bills and inquiries/appeals to the MCO.
MG	Disallowed; referring or treating provider not MCO enrolled and/or not enrolled in same MCO as claim.
MI	Disallowed; information requested by MCO is included in the MCO services. Direct inquiries to the MCO.
MJ	Disallowed; this visit is beyond the number of visits authorized per the MCO precertification. Direct inquiries/appeals to the MCO.
MK	Disallowed; this CPT code is not included in the MCO precertification. Direct inquiries/appeals to the MCO.
NA	Adjustment reflects SAIF negotiated amount.
NB	Billing adjustment applied.
ND	Adjustment applied to reflect SAIF/provider agreement.
NE	Adjustment applied to reflect an overpayment.
NF	Discount applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9)
NG	Disallowed; unlisted HCPCS must not be used if a more specific code is available per OAR 436-009-0010.
NH	Disallowed; service is not billed on the correct code per the IME contract.
NI	Adjustment applied to reflect pharmacy invoice.
NV	Adjustment applied to reflect the usual fee by similar providers for the vaccine charge per OAR 436-009-0040.
PA	Disallowed; service has been previously paid.
PB	Disallowed; service has been previously audited to zero.
PC	Disallowed; service has been previously audited and is pending payment decision.
PD	Adjustment applied to reflect rentals paid.
PE	Disallowed; maximum rentals have been paid. The item is considered purchased.
PF	Disallowed; payment was made in another SAIF claim.
RA	Adjustment applied to reflect multiple claims treated during a single visit.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
RC	Disallowed; documentation does not support the service or item billed.
RD	Disallowed; documentation does not identify injection site and/or medication/substance injected.
RE	Adjustment applied to reflect Interim Medical Benefits per OAR 436-009-0035. Partial/full reimbursement may have been made to provider by private health benefits plan.
RF	Disallowed; reimbursement request does not contain sufficient documentation/information as required by OAR 436-009-0025.
RG	Disallowed; distance traveled does not qualify for meal reimbursement.
RH	Adjustment applied to reflect allowance of the worker's meal per OAR 436-009-0025.
RI	Disallowed; pending receipt of the pharmacy slip with the name of the physician, medication, date filled, and amount paid.
RJ	Disallowed; pending receipt of the correct date of service.
RK	Disallowed; medical services and copays are not reimbursable to the worker. Medical provider must bill SAIF and reimburse worker.
RL	Reimbursement reduced or disallowed for Lost Earnings while attending a required medical exam.
RM	Disallowed; expense is not eligible for reimbursement.
RO	Disallowed; over-the-counter medications are not reimbursable unless specifically requested by the prescribing physician and approved by the claims adjuster.
RP	Disallowed; this medication requires authorization from your physician.
RQ	Disallowed; reimbursement of expense is not payable until related service has occurred.
RR	Disallowed; medication requires authorization from your Managed Care Organization (MCO).
SB	Allowance is based on the usual fees accepted by similar providers for this service.
SC	Disallowed; service requested by the employer's or worker's attorney.
SD	Unusual services; the value/allowance for this service has been increased.
SE	Disallowed; billing indicates date of service occurred prior to the date of injury.
SF	Bilateral procedure; adjusted to 50% for second procedure at same operative session per OAR 436-009-0050.
SG	Disallowed; SAIF Corporation has not authorized payment for all or part of this service.
SH	Disallowed; SAIF has no record of a medical service occurring on this date.
SI	Disallowed; charge for supply/service not normally billed or allowed.
SJ	Disallowed; interest/service charges or late fees are not payable for medical services paid timely per OAR 436-009-0030.
SL	Disallowed; charge appears unreasonable. Per OAR 436-009-0030, SAIF is submitting a dispute to the DCBS Medical Resolution Team for review.
SO	Adjustment applied to reflect late filing of vocational bill per Vocational Rehabilitation Service Agreement.
SP	Disallowed; charges need to be apportioned. SAIF Corporation may not be responsible for a portion of the charge due to compensability.
SQ	Disallowed; billing not submitted on a completed CMS-1500, UB-04, ADA or NCPDP form as required per OARs 436-009-0010 and 436-009-0020.
SR	Disallowed; documentation does not clearly identify the person providing the service as required per OAR 436-009-0010.
ST	Service previously audited to pharmacy network.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
SU	Disallowed; service appears to be billed to SAIF Corporation in error.
SV	Disallowed; modifier SG is required to identify facility charges per OAR 436-009-0023.
SW	Disallowed; provider did not request administrative review by DCBS within 90 days of the original Explanation of Benefits or submit rebill to SAIF with relevant changes per OAR 436-009-0008 or 436-009-0110.
SX	Disallowed; the IME review was not requested by SAIF. Per OAR 436-009-0060, D0019 is payable if the insurer asks the medical service provider to review an IME report and respond.
SY	Disallowed; the record review or report was not requested by SAIF. Per OAR 436-009-0040, review of records or reports are payable when requested by the insurer or their representative.
SZ	Disallowed; the charge was billed more than once.
TB	Disallowed; the service is considered preventative, not treatment. The service may be payable by the employer.
TC	Disallowed; treatment plan is not received, was received untimely, was incomplete, and/or service was not authorized by the treatment plan per OAR 436-010-0230.
TD	Disallowed; service was not performed within provider's medical license per OAR 436-009-0010.
TE	Disallowed; palliative care not authorized or exceeds authorization per OAR 436-010-0290.
TF	Disallowed; testing for hearing aids must be done by a licensed audiologist/otolaryngologist per OAR 436-009-0080.
TG	Disallowed; hearing aid(s) not authorized per OAR 436-009-0080.
TH	Only one unit is allowed. Per CPT, the code should be reported per session regardless of the time involved since it is not a time-based code.
TI	Disallowed; attending physician status per OAR 436-010-0005 and/or referral not documented.
TJ	Disallowed; service not authorized by attending physician per OAR 436-010-0220, attending physician status per OAR 436-010-0005, or referral not documented.
TK	Disallowed; service not reimbursable per CPT guidelines and/or Oregon Administrative Rules.
TL	Disallowed; this practitioner is not subject to reimbursement as a surgical assistant.
TN	Disallowed; attached documentation is illegible. Per OARs 436-009-0010 and 436-010-0240, the documentation must be legible.
TO	Disallowed; itemization of all charges is needed for reimbursement. Billing must be resubmitted with itemized charges.
TQ	Disallowed; service was not performed under the direct control and supervision of the attending physician as required per OARs 436-010-0005 and 436-010-0210.
TR	Disallowed; medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental per OAR 436-010-0300.
TS	Disallowed; billing entity is not a medical service provider, medical provider, provider of medical service, nor health insurer, and is not authorized for payment of medical services per OAR 436-009-0005 and ORS 656.313(4)(b).
TU	Disallowed; invalid or missing place of service code.
TW	Per OAR 436-009-0040, 14" x 36" lateral views are not payable.
TX	Disallowed; medication dispensed is not the initial supply as required per OAR 436-009-0090. Initial supply means the medication is dispensed on the initial date of treatment.
TY	Disallowed; medical provider not authorized/certified to provide treatment to Oregon injured workers per House Bill 2756, ORS 656.799, OARs 436-010-0005 and 436-010-0210. For clarification contact DCBS, 503-947-7606.
TZ	Only one unit is allowed. Per CPT, 97010 - 97028 are for application to one or more areas and are not timed codes. It is only appropriate to reimburse these codes one time per treatment date regardless of time or number of areas treated.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
WA	Disallowed; Longshore and Harbor Workers' Compensation (LHWCA) limits reimbursement for chiropractic services to correct a subluxation of the spine (20 CFR 702.404).
WB	Adjustment applied per external audit review.
WC	Adjustment applied to reflect the rendering provider's state fee schedule.
WG	Disallowed; the injured worker withdrew their claim. Please contact the worker to determine how to proceed.
XA	CPT 64550 changed to 97014 to relfect subsequent application of a TENS/MENS unit.
XB	The audit reflects the correct IME code. Per the IME contract, the primary specialty of the rendering provider does not qualify for reimbursement on contract code D0010.
ZB	Per OAR 436-009-0060, Oregon Specific Code D0030 is to be billed when an insurer requires a phone consultation with a medical provider. The audit reflects the correct code.
ZC	Service(s) billed under the wrong SAIF claim number. Explanation of Benefits reflects the correct claim number.
ZD	Date(s) of service corrected to reflect documentation.
ZE	Per OAR 436-030-0020, a closing exam is only required if impairment is anticipated. This claim is designated as non-disabling. Reimbursement is made on the documented E/M level of service.
ZF	Exam did not result in claim closure. Therefore, closing exam code is changed to reflect the documented level of E/M service.
ZG	Closing exam previously performed for claim closure. Service code has been changed to reflect the documented level of E/M service.
ZH	Service code has been changed to reflect the correct code for a closing exam.
ZI	Per OAR 436-009-0060, the appropriate code for review and response to an IME report is Oregon Specific Code D0019. The audit reflects the correct code.
ZJ	Service code changed to reflect the correct report code.
ZK	Per OAR 436-010-0230, service code is reduced to reflect what is required for the nature of the compensable injury or process of recovery.
ZL	The audit reflects the documented level of service. Per OAR 436-009-0030, any service billed with a code number commanding a higher fee than the services provided shall be paid at the value of the service provided.
ZM	Manipulation code is reduced to reflect treatment of condition(s) related to this claim.
ZN	The severity of the worker's injury does meet the criteria for the code billed. Servcie code has been reduced to reflect the appropriate code per CPT guidelines.
ZO	Incorrect, obsolete or invalid service code has been changed to reflect the correct code.
ZP	Evaluation changed to re-eval to reflect previous reimbursement of initial evaluation.
ZQ	Service code has been changed to reflect an established patient visit.
ZR	Reimbursement is made for one record copy since billing does not indicate the number of copies provided.
ZS	Per OAR 436-009-0060, Oregon Specific Code R0001 is the correct code for copies of requested medical records.
ZT	Service code has been changed to reflect the correct IME code.
ZU	The audit reflects the correct CPT code or Oregon Specific Code. Per OAR 436-009-0010, HCPCS codes may be used only if there is no specific CPT code or Oregon Specific Code.
ZV	Quantity has been changed for medication dispensed to reflect a maximum 10-day supply as required per OAR 436-010-0230.
ZW	Provider is rebilling for the MCO withhold previously taken. Managed Care Organization (MCO) withholds are taken per the provider's contract with the MCO. Contact the MCO for further clarification.

Explanation of Benefits - Adjustment Codes

Code	CBP Reason
ZX	Per OAR 436-010-0230, a reasonable charge may be made for the delivery costs of diagnostic studies. Sufficient reimbursement has been made to cover the cost for delivery of the x-ray films.
ZY	Service code has been changed to reflect the correct code for interpreter services.
ZZ	Service code has been changed to reflect the correct code for interpreter mileage.