Explanation of Benefits - Standard Codes
Standard Adjustment Code Description

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Reason Code	Reason Description	Remark Code	Remark Description	SAIF Code	Adjustment Description
100	Payment made to patient/insured/responsible party/employer	M86	Service denied because payment already made for same/similar procedure within set time frame.	BB	Reimbursement made to the employer.
100	Payment made to patient/insured/responsible party/employer	M86	Service denied because payment already made for same/similar procedure within set time frame.	BC	Reimbursement made to the worker.
104	Managed care withholding.			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.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.			SC	Disallowed; service requested by the employer's or worker's attorney.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	CE	Disallowed; charges also made for "asterisk procedure" on this date, per CPT surgery guidelines.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	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.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	IT	Disallowed; drug/alcohol testing is not payable. The service may be payable by the employer.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	NC	Adjusted to reflect out of state reimbursement schedule.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	SN	Disallowed; provider practice restrictions are enforced per OARs 436-010-0005(10) and 436-010-0210.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	TM	Disallowed; except in an emergency, oral drugs and medicine supplied by a physician's office are not reimbursable per OAR 436-10-0230.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N55	Procedures for billing with group/referring/performing providers were not followed.	TP	Disallowed; practitioner is not licensed to provide medical service per OARs 436-010-0005 and 436-010-0210.
131	Bill specific negotiated discount	N55	Procedures for billing with group/referring/performing providers were not followed.	WD	Three Rivers Provider Network (TRPN) discount applied. Contact TRPN for clarification, 619-230-0769.
131	Bill specific negotiated discount	N55	Procedures for billing with group/referring/performing providers were not followed.	WE	Adjustment taken through Apropô Benefits Management. If you have questions, please contact Apropô at 1-800-617-9107.
133	The disposition of the claim/service is pending further review.	N202	Additional information/explanation will be sent separately	PC	Disallowed; service has been previously audited and is pending payment decision.

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133	The disposition of the claim/service is pending further review.	N202	Additional information/explanation will be sent separately	SL	Disallowed; charge appears unreasonable. Per OAR 436-009-0030, SAIF is submitting a dispute to the DCBS Medical Resolution Team for review.
138	Appeal procedures not followed or time limits not met	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	GG	Disallowed; documentation does not support 3-D imaging was rendered. Per CPT, 2-D reformatting is not a separately reportable service.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	GH	Disallowed; documentation does not support post-processing of 3-D rendering on an independent workstation.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	GI	Disallowed; documentation does not support an independent trained observer was present to monitor the patient's level of consciousness and physiological status.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	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.
150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	GU	Disallowed; documenation does not clearly identify regions treated.

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150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.	RC	Disallowed; documentation does not support the service or item billed.
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.	XA	CPT 64550 changed to 97014 to relfect subsequent application of a TENS/MENS unit.
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.	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.
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.	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.
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.	ZG	Closing exam previously performed for claim closure. Service code has been changed to reflect the documented level of E/M service.
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.	ZH	Service code has been changed to reflect the correct code for a closing exam.
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.	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.
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.	ZJ	Service code changed to reflect the correct report code.
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.	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.
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.	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.
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.	ZO	Incorrect, obsolete or invalid service code has been changed to reflect the correct code.
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.	ZP	Evaluation changed to re-eval to reflect previous reimbursement of initial evaluation.
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.	ZQ	Service code has been changed to reflect an established patient visit.
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.	ZT	Service code has been changed to reflect the correct IME code.

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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.	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.
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.	ZY	Service code has been changed to reflect the correct code for interpreter services.
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.	ZZ	Service code has been changed to reflect the correct code for interpreter mileage.
152	Information submitted does not support this length of service	N125	Payment has been (denied/made a less extensive) service/item because the info furnished does not substantiate the need for more extensive service/item	SM	Disallowed; length of stay exceeds acute care criteria.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC)	FA	Disallowed; NDC required for pharmaceutical service per OAR 436-009-0090 and OAR 436-009-0010 is missing or invalid.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M20	Missing/incomplete/invalid HCPCS.	FS	Disallowed; HCPCS codes are required per OAR 436-009-0010.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M20	Missing/incomplete/invalid HCPCS.	NG	Disallowed; unlisted HCPCS must not be used if a more specific code is available per OAR 436-009-0010.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M51	Missing/incomplete/invalid procedure code(s).	FF	Disallowed; service code is missing, incorrect, or invalid per CPT, CDT, HCPCS, NDC or Oregon Administrative Rules.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M51	Missing/incomplete/invalid procedure code(s).	II	Disallowed; service must be billed on appropriate Oregon Specific Code per OAR 436-009-0060.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M51	Missing/incomplete/invalid procedure code(s).	NH	Disallowed; service is not billed on the correct code per the IME contract.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M52	Missing/incomplete/invalid 'from' date(s) of service.	RJ	Disallowed; pending receipt of the correct date of service.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M76	Missing/incomplete/invalid diagnosis or condition.	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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	M77	Missing/incomplete/invalid place of service.	TU	Disallowed; invalid or missing place of service code.

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16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N208	Missing/incomplete/invalid DRG code	GS	Disallowed; missing or invalid MS-DRG code billed. The MS-DRG is required per OAR 436-009-0020.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N289	Missing/incomplete/invalid rendering provider name	GC	Disallowed; invoice does not include the name of the interpreter per OAR 436-009-0110.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N289	Missing/incomplete/invalid rendering provider name	GL	Disallowed; the documentation does not clearly identify the name of the person performing the treatment as required per OAR 436-009-0010. It appears an LMT may have performed this service.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N289	Missing/incomplete/invalid rendering provider name	GV	Disallowed; each chart note entry must identify the provider of service per OAR 811-015-0005.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N289	Missing/incomplete/invalid rendering provider name	SR	Disallowed; documentation does not clearly identify the person providing the service as required per OAR 436-009-0010.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N29	Missing documentation/orders/notes/summary/report/chart	RF	Disallowed; reimbursement request does not contain sufficient documentation/information as required by OAR 436-009-0025.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N29	Missing documentation/orders/notes/summary/report/chart	RI	Disallowed; pending receipt of the pharmacy slip with the name of the physician, medication, date filled, and amount paid.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N299	Missing/incomplete/invalid occurrence date(s)	ZD	Date(s) of service corrected to reflect documentation.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N31	Missing/imcomplete/invalid prescribing provider identifier.	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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N34	Incorrect claim form/format for this service.	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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N349	The administration method and drug must be reported to adjudicate this service.	RD	Disallowed; documentation does not identify injection site and/or medication/substance injected.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	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.

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16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	GA	Disallowed; invoice does not include the total amount of time spent interpreting per OAR 436-009-0110.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end 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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	GO	Adjustment applied per OAR 436-009-0110 to reflect treatment time documented by the medical provider. Clarification of additional interpreter time is needed.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	GP	Disallowed; documentation does not indicate the face-to-face psychotherapy time.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end 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.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N443	Missing/incomplete/invalid total time or begin/end time.	GR	Disallowed; time spent reviewing the records or reports is not documented per OAR 436-009-0040.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N517	Resubmit a new claim with the requested information.	GY	Disallowed; invalid/missing admit code. Required per OAR 436-009-0010.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N55	Procedures for billing with group/referring/performing providers were not followed.	GB	Disallowed; invoice does not include the name and/or address of the medical provider per OAR 436-009-0110.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N55	Procedures for billing with group/referring/performing providers were not followed.	GD	Disallowed; interpreter mileage cannot be verifed. Starting address is needed per OARs 436-009-0110.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N55	Procedures for billing with group/referring/performing providers were not followed.	MB	Disallowed pending clarification of pharmacy item/measurement/dosage.

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16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N55	Procedures for billing with group/referring/performing providers were not followed.	MH	Disallowed pending receipt of invoice pursuant to the MCO contract.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N55	Procedures for billing with group/referring/performing providers were not followed.	SU	Disallowed; service appears to be billed to SAIF Corporation in error.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number	ZC	Service(s) billed under the wrong SAIF claim number. Explanation of Benefits reflects the correct claim number.
163	Attachment/other documentation referenced on the claim was not received.	M135	Missing/incomplete/invalid plan of treatment.	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.
163	Attachment/other documentation referenced on the claim was not received.	M23	Missing invoice.	FZ	Disallowed; ASC's implant cost required per 436-009-0023.
163	Attachment/other documentation referenced on the claim was not received.	M31	Missing radiology report.	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.
163	Attachment/other documentation referenced on the claim was not received.	N205	Information provided was illegible	TN	Disallowed; attached documentation is illegible. Per OARs 436-009-0010 and 436-010-0240, the documentation must be legible.
163	Attachment/other documentation referenced on the claim was not received.	N26	Missing itemized bill/statement.	TO	Disallowed; itemization of all charges is needed for reimbursement. Billing must be resubmitted with itemized charges.
163	Attachment/other documentation referenced on the claim was not received.	N29	Missing documentation/orders/notes/summary/report/chart	FW	Disallowed; required documentation supporting the service/item billed is not attached per Oregon Administrative Rules. Billing must be resubmitted with supporting documentation.
163	Attachment/other documentation referenced on the claim was not received.	N29	Missing documentation/orders/notes/summary/report/chart	SH	Disallowed; SAIF has no record of a medical service occurring on this date.
163	Attachment/other documentation referenced on the claim was not received.	N395	Missing/incomplete/invalid diagnosis or condition.	GN	Disallowed; report of laboratory findings is required.
170	Payment is denied when performed/billed by this type of provider.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	TD	Disallowed; service was not performed within provider's medical license per OAR 436-009-0010.
170	Payment is denied when performed/billed by this type of provider.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	TF	Disallowed; testing for hearing aids must be done by a licensed audiologist/otolaryngologist per OAR 436-009-0080.
170	Payment is denied when performed/billed by this type of provider.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	TL	Disallowed; this practitioner is not subject to reimbursement as a surgical assistant.

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18	Exact duplicate claim/service	M86	Service denied because payment already made for same/similar procedure within set time frame.	EA	Disallowed; the medical arbiter has been previously reimbursed for file review of the same records in less than 10 business days.
18	Exact duplicate claim/service	M86	Service denied because payment already made for same/similar procedure within set time frame.	PA	Disallowed; service has been previously paid.
18	Exact duplicate claim/service	M86	Service denied because payment already made for same/similar procedure within set time frame.	PD	Adjustment applied to reflect rentals paid.
18	Exact duplicate claim/service	M86	Service denied because payment already made for same/similar procedure within set time frame.	PF	Disallowed; payment was made in another SAIF claim.
18	Exact duplicate claim/service	M86	Service denied because payment already made for same/similar procedure within set time frame.	ST	Service previously audited to pharmacy network.
18	Exact duplicate claim/service	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	PB	Disallowed; service has been previously audited to zero.
18	Exact duplicate claim/service	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	SZ	Disallowed; the charge was billed more than once.
185	The rendering provider is not eligible to perform the service billed.	N32	Claim must be submitted by the provider who rendered the service	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).
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	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.
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	MD	Disallowed; audited to MCO guidelines/certification/contract or unable to verify certification of services. Direct inquiries/appeals to the MCO.
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	RN	Disallowed; non-certified medications are not payable.
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	RP	Disallowed; this medication requires authorization from your physician.
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	RR	Disallowed; medication requires authorization from your Managed Care Organization (MCO).
197	Precertification/authorization/notification absent.	N54	Claim information is inconsistent with pre-certified/authorized services.	TE	Disallowed; palliative care not authorized or exceeds authorization per OAR 436-010-0290.
198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	MJ	Disallowed; this visit is beyond the number of visits authorized per the MCO precertification. Direct inquiries/appeals to the MCO.

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198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.	MK	Disallowed; this CPT code is not included in the MCO precertification. Direct inquiries/appeals to the MCO.
216	Based on the findings of a review organization			WB	Adjustment applied per external audit review.
216	Based on the findings of a review organization	N55	Procedures for billing with group/referring/performing providers were not followed.	WF	Adjusted per FAIRPAY Solutions, Inc. review. If you have questions about this adjustment, please contact FairPay at 888.380.5616.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	M86	Service denied because payment already made for same/similar procedure within set time frame.	BA	Reimbursement made to another insurance company.
242	Services not provided by network/primary care providers.	N54	Claim information is inconsistent with pre-certified/authorized services.	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.
242	Services not provided by network/primary care providers.	N54	Claim information is inconsistent with pre-certified/authorized services.	MG	Disallowed; referring or treating provider not MCO enrolled and/or not enrolled in same MCO as claim.
256	Service not payable per managed care contract.	N55	Procedures for billing with group/referring/performing providers were not followed.	ME	Disallowed; service not payable per SAIF/MCO contract. Direct bills and inquiries/appeals to the MCO.
256	Service not payable per managed care contract.	N55	Procedures for billing with group/referring/performing providers were not followed.	MI	Disallowed; information requested by MCO is included in the MCO services. Direct inquiries to the MCO.
29	The time limit for filing has expired.	N55	Procedures for billing with group/referring/performing providers were not followed.	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.
29	The time limit for filing has expired.	N55	Procedures for billing with group/referring/performing providers were not followed.	SO	Adjustment applied to reflect late filing of vocational bill per Vocational Rehabilitation Service Agreement.
29	The time limit for filing has expired.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
29	The time limit for filing has expired.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	FN	Disallowed; worker reimbursement exceeds two years and is not timely per OAR 436-009-0025.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	ZA	Per OAR 436-009-0015(10), modifier -81 must be billed for Nurse Practitioner and Physician Assistant services. Modifier 81 was applied to the audit.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517	Resubmit a new claim with the requested information.	SS	Disallowed; Nurse Practitioner and Physician Assistant billings require modifier 81 per OAR 436-009-0010(6).
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517	Resubmit a new claim with the requested information.	SV	Disallowed; modifier SG is required to identify facility charges per OAR 436-009-0023.

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45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	PE	Disallowed; maximum rentals have been paid. The item is considered purchased.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.	RA	Adjustment applied to reflect multiple claims treated during a single visit.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	MA	Adjustment applied for MCO contract package price.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	MC	Adjustment applied to reflect MCO contract rate or discount. Direct inquiries/appeals to the MCO.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	NA	Adjustment reflects SAIF negotiated amount.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	ND	Adjustment applied to reflect SAIF/provider agreement.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N449	Payment based on a comparable drug/service/supply.	NV	Adjustment applied to reflect the usual fee by similar providers for the vaccine charge per OAR 436-009-0040.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N449	Payment based on a comparable drug/service/supply.	SB	Allowance is based on the usual fees accepted by similar providers for this service.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	FI	Adjustment applied to reflect the fee schedule for rendering surgical or post-operative care only.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	FM	Co-surgeons/two surgeons; 25% reduction per OAR 436-009-0040 or per provider's billing agreement.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	FT	Fee schedule applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9).

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45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	IJ	Adjustment is applied to reflect total interpreter time for consecutive appointments by the same interpreter.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	IV	Adjustment is applied to reflect 50% reduction per anesthesia modifier QK, QX, or QY.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	NF	Discount applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9)
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	RH	Adjustment applied to reflect allowance of the worker's meal per OAR 436-009-0025.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	RL	Reimbursement reduced or disallowed for Lost Earnings while attending a required medical exam.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	ZR	Reimbursement is made for one record copy since billing does not indicate the number of copies provided.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	ZS	Per OAR 436-009-0060, Oregon Specific Code R0001 is the correct code for copies of requested medical records.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N54	Claim information is inconsistent with pre-certified/authorized services.	SK	Disallowed; item/service not required for treatment of compensable condition or process of recovery per OAR 436-010-0230.
52		N55	Procedures for billing with group/referring/performing providers were not followed.	IM	Disallowed; provider must be CARF or JCAHO accredited for reimbursement on multidisciplinary service codes per OAR 436-009-0060.
59	Processed based on multiple or concurrent procedure rules	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	FH	Adjustment applied to reflect multiple studies done within two days, per OAR 436-009-0040.
59	Processed based on multiple or concurrent procedure rules	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	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.

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70	Cost outlier - adjustment to compensate for additional costs	N199	Additional payment/recoupment approved based on payer-initiated review/audit.	SD	Unusual services; the value/allowance for this service has been increased.
88		N199	Additional payment/recoupment approved based on payer-initiated review/audit.	NE	Adjustment applied to reflect an overpayment.
96	Non-covered charge(s).	N356	Not covered when performed with, or subsequent to, a non-covered service.	SP	Disallowed; charges need to be apportioned. SAIF Corporation may not be responsible for a portion of the charge due to compensability.
96	Non-covered charge(s).	N441	This missed/cancelled appointment is not covered.	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.
96	Non-covered charge(s).	N441	This missed/cancelled appointment is not covered.	IB	Adjustment applied to reflect appropriate allowance per OAR 436-009-0110.
96	Non-covered charge(s).	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	EO	Disallowed; completion of clinical justification form required per OAR 436-009-0090, is not reimbursable.
96	Non-covered charge(s).	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	FE	Disallowed; report, form, or chart note copies are required per OARs 436-009-0010 & 436-009-0090.
96	Non-covered charge(s).	N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive /inappropriate.	TR	Disallowed; medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental per OAR 436-010-0300.
96	Non-covered charge(s).	N624	The associated Workers' Compensation claim has been withdrawn.	WG	Disallowed; the injured worker withdrew their claim. Please contact the worker to determine how to proceed.
96	Non-covered charge(s).	N629	Reviews/documentation/notes/summaries/reports/chart s not requested.	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.
96	Non-covered charge(s).	N629	Reviews/documentation/notes/summaries/reports/chart s not requested.	IH	Disallowed; physician certification of the patient's home health plan is not required for workers' compensation and was not requested.
96	Non-covered charge(s).	N629	Reviews/documentation/notes/summaries/reports/chart s not requested.	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.
96	Non-covered charge(s).	N629	Reviews/documentation/notes/summaries/reports/chart s not requested.	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.

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96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	CM	Disallowed; service is included in the ASC facility fee per OAR 436-009-0023.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	EC	Disallowed; communication between one healthcare provider to another healthcare provider is not reimbursable.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	ES	Disallowed; surface EMGs are not payable per OAR 436-009-0010.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	ET	Disallowed; thermography is not payable per OAR 436-009-0010.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	EV	Disallowed; service is not payable per OAR 436-009-0010.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	EW	Disallowed; vitamin B-12 injections and dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not payable per OAR 436-010-0230(8). Formula 303 is also not payable.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	EZ	Disallowed; utilization of homeopathic substances are not payable per OAR 436-010-0230.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IA	Disallowed; the person providing the interpreter services does not qualify for reimbursement per OARs 436-009-0005 and 436-009-0110.

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96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IC	Disallowed; distance traveled by interpreter does not qualify for reimbursement per OARs 436-009-0110.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IE	Disallowed; charge is not payable. Per OARs 436-009-0110, only interpreter services and mileage are reimbursable.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IF	Disallowed; an interpreter may only bill an insurer per OARs 436-009-0110. Interpreter billings submitted by medical providers are not payable.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IN	Disallowed; services are not payable under ORS 656.313 and OAR 436-060-0190 which specifies circumstances for health insurance reimbursement.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	IU	Disallowed; treatment time less than 8 minutes is not payable for a time based physical medicine code per OAR 436-009-0040.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	SJ	Disallowed; interest/service charges or late fees are not payable for medical services paid timely per OAR 436-009-0030.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	TA	Disallowed; dietary supplements, including but not limited to, minerals, vitamins and amino acids, or homeopathic substances are not reimbursable per OAR 436-009-0010.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	TK	Disallowed; service not reimbursable per CPT guidelines and/or Oregon Administrative Rules.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	TV	Disallowed; non-prescription topical creams, gels, ointments, lotions, or sprays are not reimbursable per OAR 436-010-0230.
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	TW	Per OAR 436-009-0040, 14" x 36" lateral views are not payable.

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96	Non-covered charge(s).	N652	The date of service is before the date of loss.	SE	Disallowed; billing indicates date of service occurred prior to the date of injury.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	Service denied because payment already made for same/similar procedure within set time frame.	BD	Reimbursement has already been made to the rendering provider.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	Service denied because payment already made for same/similar procedure within set time frame.	BE	Adjustment applied for amount the worker paid toward prescription cost.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N472	Payment for this service has been issued to another provider.	EB	Disallowed; only the physician who prepares and submits the report shall receive the fee for the report per DCBS billing instructions.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N525	These services are not covered when performed within the global period of another service.	CA	Disallowed; postoperative visit included in surgical/global fee.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N525	These services are not covered when performed within the global period of another service.	CC	Disallowed; preoperative evaluation related to an elective surgery is included in the global surgery fee per OAR 436-009-0040.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N525	These services are not covered when performed within the global period of another service.	CD	Adjustment applied for previously allowed global (pre-op and/or post-op) service.
A1	Bill/service denied	M52	Missing/incomplete/invalid 'from' date(s) of service.	RQ	Disallowed; reimbursement of expense is not payable until related service has occurred.
A1	Bill/service denied	N55	Procedures for billing with group/referring/performing providers were not followed.	EL	Disallowed; requested record review of less than 30 minutes total duration is not separately report/billed per CPT guidelines.
A1	Bill/service denied	N55	Procedures for billing with group/referring/performing providers were not followed.	EP	Disallowed; prolonged service less than 30 minutes total duration on a given date is not separately reported/billed per CPT guidelines.
A1	Bill/service denied	N567	Not covered when considered preventative	TB	Disallowed; the service is considered preventative, not treatment. The service may be payable by the employer.
A1	Bill/service denied	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	RG	Disallowed; distance traveled does not qualify for meal reimbursement.
A1	Bill/service denied	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	RK	Disallowed; medical services and copays are not reimbursable to the worker. Medical provider must bill SAIF and reimburse worker.
A1	Bill/service denied	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	RM	Disallowed; expense is not eligible for reimbursement.

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A1	Bill/service denied	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	RO	Disallowed; over-the-counter medications are not reimbursable unless specifically requested by the prescribing physician and approved by the claims adjuster.
A1	Bill/service denied	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	SI	Disallowed; charge for supply/service not normally billed or allowed.
B7	Provider not certified/eligible to be paid for this procedure/service on this date of service	N54	Claim information is inconsistent with pre-certified/authorized services.	SG	Disallowed; SAIF Corporation has not authorized payment for all or part of this service.
B7	Provider not certified/eligible to be paid for this procedure/service on this date of service	N54	Claim information is inconsistent with pre-certified/authorized services.	TG	Disallowed; hearing aid(s) not authorized per OAR 436-009-0080.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	FJ	Disallowed; service exceeds physical medicine 3-code daily maximum per OAR 436-009-0040(6).
P12	Workers' compensation jurisdictional fee schedule adjustment.	N442	Payment based on an alternate fee schedule.	WA	Disallowed; Longshore and Harbor Workers' Compensation (LHWCA) limits reimbursement for chiropractic services to correct a subluxation of the spine (20 CFR 702.404).
P12	Workers' compensation jurisdictional fee schedule adjustment.	N442	Payment based on an alternate fee schedule.	WC	Adjustment applied to reflect the rendering provider's state fee schedule.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N644	Reimbursement has been made according to the bilateral procedure rule.	SF	Bilateral procedure; adjusted to 50% for second procedure at same operative session per OAR 436-009-0050.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N646	Reimbursement has been adjusted based on the guidelines for an assistant	FC	Adjustment applied for physician assistant or nurse practitioner fees per OAR 436-009-0010(6).
P12	Workers' compensation jurisdictional fee schedule adjustment.	N646	Reimbursement has been adjusted based on the guidelines for an assistant	FO	Adjustment applied for MD surgical assistant to 20% of primary surgeon's payment per OAR 436-009-0040.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N646	Reimbursement has been adjusted based on the guidelines for an assistant	FP	Adjustment applied for physician assistant or nurse practitioner surgical assistance per OAR 436-009-0040.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N646	Reimbursement has been adjusted based on the guidelines for an assistant	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.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N649	Payment based on invoice.	FG	Adjustment applied to DME or implant per OAR 436-009-0023.
P12	Workers' compensation jurisdictional fee schedule adjustment.	N649	Payment based on invoice.	NI	Adjustment applied to reflect pharmacy invoice.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N199	Additional payment/recoupment approved based on payer-initiated review/audit.	NB	Billing adjustment applied.

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P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N202	Additional information/explanation will be sent separately	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.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N22	This procedure code was added/changed because it more accurately describes the services rendered.	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.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N22	This procedure code was added/changed because it more accurately describes the services rendered.	ZF	Exam did not result in claim closure. Therefore, closing exam code is changed to reflect the documented level of E/M service.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N524	Based on policy this payment constitutes payment in full	AA	Adjustment applied per Department of Consumer and Business Services (DCBS) decision/order. Appeals must be directed to DCBS.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	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.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	ZV	Quantity has been changed for medication dispensed to reflect a maximum 10-day supply as required per OAR 436-010-0230.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N607	Service provided for non-compensable condition(s).	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.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N607	Service provided for non-compensable condition(s).	ZM	Manipulation code is reduced to reflect treatment of condition(s) related to this claim.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies	N671	Payment based on a jurisdiction cost-charge ratio.	FX	Adjustment applied to reflect Hospital cost-charge ratio/fee schedule per OAR 436-009-0020.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CB	Disallowed; procedure is unbundled, performed in conjunction with, or included in another procedure or visit.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CF	Disallowed; fitting and adjusting is included in the orthotic/prosthetic code billed.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CG	Disallowed; supplies required for treatment or diagnostic procedure are not separately reimbursable.

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P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CH	Disallowed; only supplies over and above those usually included with the office visit or procedure(s) rendered may be reported separately per CPT.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	EQ	Disallowed; CPTs 99455-99456 are not timed codes. Prolonged service is not payable.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.

Explanation of Benefits - Standard Codes
Standard Adjustment Code Description

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Reason Code	Reason Description	Remark Code	Remark Description	SAIF Code	Adjustment Description
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	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.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	M97	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	IS	Disallowed; equipment directly related to the provision of the surgical procedure is included in the ASC facility fee per OAR 436-009-0023.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	N55	Procedures for billing with group/referring/performing providers were not followed.	IR	Disallowed; non-physician service billable on EM service level 99211 only.
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	N54	Claim information is inconsistent with pre-certified/authorized services.	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.
P17	Referral not authorized by attending physician per regulatory requirement.			TI	Disallowed; attending physician status per OAR 436-010-0005 and/or referral not documented.
P17	Referral not authorized by attending physician per regulatory requirement.			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.
P3	Workers' Compensation case settled	N607	Service provided for non-compensable condition(s).	DC	Disallowed; claim settlement has been issued.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	N585	Benefits are no longer available based on a final injury settlement.	DF	Disallowed; claim denial is final. Private insurance may now be billed.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	N607	Service provided for non-compensable condition(s).	DA	Disallowed; aggravation denial issued or not perfected.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	N607	Service provided for non-compensable condition(s).	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.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	N607	Service provided for non-compensable condition(s).	DD	Disallowed; service appears to be unrelated to a compensable condition.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	N607	Service provided for non-compensable condition(s).	DE	Disallowed; partial denial of condition, current condition denial, or combined condition denial has been issued.

Explanation of Benefits - Standard Codes
Standard Adjustment Code Description

Reason Code	Reason Description	Remark Code	Remark Description	SAIF Code	Adjustment Description
W1	Workers compensation jurisdictional fee schedule adjustment	N55	Procedures for billing with group/referring/performing providers were not followed.	TT	Disallowed; medication dispensed is not for a maximum of ten days as required per OAR 436-010-0230(6).
W1	Workers compensation jurisdictional fee schedule adjustment	N606	Oregon allowed amount for procedure based upon the Workers Comp Fee Schedule (OAR 436-009).	SA	Adjustment applied to reflect the actual amount of interpretive time. Per OAR 436-009-0010, providers must not submit billings for services not provided.