Optum Alaska
205 East Benson Boulevard
Anchorage, Alaska 99503

Alaska Medicaid Provider Update

Remittance Advice Code and Denial Reason List

September 30, 2021

Optum uses the national codes for claim adjustment and remittance advice reason codes. The link to the national codes is: https://x12.org/codes. In addition, this update contains the Optum claim codes and reasons.

Optum Alaska Claim Codes

Facets Code	CARC Code	RARC Code	Internal Short Description	Internal Long Description	Liability
002			Increased allowable	Increased allowable	NA
003			Reduced allowable	Reduced allowable	NA
017			Increased allowable units	Increased allowable units	NA
018			Reduced allowable units	Reduced allowable units	NA
073			Deny All Claim Lines	Deny All Claim Lines	NA
346	18	0	Duplicate	Duplicate	NA
Ak6	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
AKT	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
B01	11	0	Invalid Diagnosis/CPT Combination	This is an invalid diagnosis code and procedure code combination.	Provider
B02	96	N130	Service Not Covered for this Provider	This service is not covered for this provider under your plan.	Member
B05	96	N130	Your plan does not cover this expense	Your Behavioral Health Plan does not cover this expense.	Member
B08	5	M77	Place of svs inappropriate for procedure	This place of service is inappropriate for this service.	Provider
B14	109	N418	Please forward to correct carrier	Medical Services not covered under Behavioral Health coverage. Please submit claim to your Medical Health Plan for processing.	Provider
B37	96	N130	OON provider-Svcs not covered for plan	Your plan does not cover services you received from a non-network provider.	Member
B45	181	N56	This is not a reimbursable service.	This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service.	Provider
B46	182	517	Invalid Procedure Modifier Combination	Invalid procedure modifier combination.	Provider
B47	6	N129	Inconsistent with patient's age	The submitted procedure is disallowed because it is inconsistent with the patient's age.	Provider
B62	16	N77	Individual provider name, license req	Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.	Provider
CD0	119	N362	Exceeds Clinical Review Criteria	This session has exceeded the clinical review criteria. You can obtain medical necessity review upon appeal.	Provider

CDD	18	N522	Definite Duplicate Claim	This claim is a duplicate of a previously submitted claim for this member.	NA
DNA	243	N130	Deny due to No Authorization	Deny due to No Authorization	Provider
eA1			Contraindicated Service	Contraindicated Service	Provider
EEA	96	N95	AK- Lock in Program	Alaska Lock in Program	Provider
FBM	163	N706	TPL Indicated No Resource on File	TPL Indicated on Claim Form - No Resource on State File	Provider
FD1			Submit Active Diagnosis for DOS	Submit Active Diagnosis for DOS.	Provider
FEA	96	N95	AK - Lock in Program	Alaska Lock in Program	Provider
FOD	16	N77	Individual provider name, license req	Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.	Provider
j01			COB Allowable Amount Override	A COB override has occurred on this claim.	NA
L03	16	N418	Send Primary Carrier EOB for this charge	Send Primary Carrier EOB for this charge.	Notification
N29	119	N435	Exceeds Clinical Review Criteria	This session has exceeded the clinical review criteria. You can obtain medical necessity review upon appeal.	Provider
N78	16	M64	Invalid Diagnosis Code	Invalid Diagnosis Code.	Provider
PAK	45	0	Exceeds per diem rate	Exceeds per diem rate.	Notification
PS	45	0	Your plan does not cover this expense.	Your Behavioral Health Plan does not cover this expense.	Member
PSC	45	0	Exceeds the R&C Rate	Benefits are reduced because a Network Provider was not used. The Patient is responsible for any difference between the charge and paid amt.	Member
PSS	45	0	Exceeds the Scheduled Rate	Charge exceeds allowable rate for this service or code submitted is not on contracted fee schedule- contact Network Manager for correct code.	Notification
S1A	31	0	No eligibility found	The member's coverage was not in effect on the date the service was provided.	Member
S1C	26	N30	Plan not effective on date requested	The Member's coverage was not in effect on the date the service was provided.	Member
S20	26	N30	Date req. prior to Member Orig. Eff Date	The Member's coverage was not in effect on the date services were provided.	Member
S21	26	N30	Date req. prior to Group Effective Date	The Member's coverage was not in effect on the date services were provided.	Member
S22	26	N30	Date req. prior to subgroup orig eff dt.	The Member's coverage was not in effect on the date services were provided.	Member
S23	26	N	Deny req. Prior to Subscriber Eff Dt	The Member's coverage was not in effect on the date services were provided.	Member
SN	31	0	Non-eligible member	Member not eligible for benefits.	Member
SS	27	N30	Separation - Member	Termination via Member-level separation event.	Member
ST	27	N650	Termination	Member not eligible for Benefits.	Member
TF0	29	0	Submitted after plan filing limit	This claim was submitted after the claim filing limit.	Provider
TF1	29	0	Submitted After Provider's Filing Limit	Claim submitted after filing limit.	Provider
TMA	27	N30	Group Termination	Member not eligible.	Member
UM1	50	N362	Units exceed UM authorization	Units exceed a Utilization Management authorization.	Provider
UM2	50	N362	Units reduced by UM authorization	Units were reduced by a utilization management authorization.	Provider
W19			DX Code missing 4th or 5th	Missing/incomplete/invalid/other diagnosis code.	Provider

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W37	96	N130	OON provider-Svcs not covered for plan	Your plan does not cover services you received from a non-network provider.	Member
WCF	16	N34	Correct Claim Format Required	Incorrect claim form/format for this service(s).	Provider
Z06			Deny due to No Authorization	Deny due to No Authorization.	Provider

Claim Adjustment Reason Codes (CARC) Codes

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

Remittance Advice Remark Coding (RARC) Codes

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