Adjustment Codes - 06.26.2024

Code	Short Description	Long Description
AA	DCBS decision/order	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	Reimbursement made to another insurance company.
BB	Reimbursement made to the employer	Reimbursement made to the employer.
BC	Reimbursement made to the worker	Reimbursement made to the worker.
BD	Reimbursement has already been made to the	Reimbursement has already been made to the rendering provider.
BE	Prescription co-payment made by worker	Adjustment applied for amount the worker paid toward prescription cost.
CA	Post op visit included in surgical/global fee	Disallowed; postoperative visit included in surgical/global fee.
CB	Procedure unbundled from or included in another service	Disallowed; procedure is unbundled, performed in conjunction with, or included in another procedure or visit.
CC	Considered part of surgical/global fee	Disallowed; preoperative evaluation related to an elective surgery is included in the global surgery fee per OAR 436-009-0040.
CD	Previously allowed global service	Adjustment applied for previously allowed global (pre-op and/or post-op) service.
CF	Fitting and adjusting included in prosthetic/orthotic	Disallowed; fitting and adjusting is included in the orthotic/prosthetic code billed.
CG	Electrodes/needles are not payable	Disallowed; supplies required for treatment or diagnostic procedure are not separately reimbursable.
CH	Unbundled medical supplies used in the office	Disallowed; only supplies over and above those usually included with the office visit or procedure(s) rendered may be reported separately per CPT.
CI	Timed codes billed by region	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	CPT 65435 included in CPTs 65220 or 65222	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	One unit payable for rapid urine check or urine screen	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	Electric stimulation not billed with 97810 or 97811	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	Included in ASC facility fee	Disallowed; service is included in the ASC facility fee per OAR 436-009-0023.
CN	Service included in surgical procedure.	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	Aggravation denial issued or not perfected	Disallowed; aggravation denial issued or not perfected.
DB	Claim denied or in litigation	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	Claim settlement	Disallowed; claim settlement has been issued.

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DD	Service appears to be unrelated to compensable condition	Disallowed; service appears to be unrelated to a compensable condition.
DE	Partial, current or combined condition denial issued	Disallowed; partial denial of condition, current condition denial, or combined condition denial has been issued.
DF	Claim denial is final; private insurance may now be	Disallowed; claim denial is final. Private insurance may now be billed.
EA	Arbiter previously reimbursed for file review	Disallowed; the medical arbiter has been previously reimbursed for file review of the same records in less than 10 business days.
EB	Arbiter report payable to only one physician	Disallowed; reimbursement has been made to another physician, the preparer of the report. Per OAR 436-009-0070, the physician who prepares and submits the report shall receive the fee for the report.
EC	Communication between providers not payable	Disallowed; communication between one healthcare provider to another healthcare provider is not reimbursable.
ED	CPT 97010 - 97028 billed alone not payable	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-
EE	Billing sent to SAIF's legal department	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. 8634.
EF	Fracture w/o manipulation code not payable	Disallowed; initial care of a fracture/dislocation by the ER physician should be billed on the appropriate cast, splint, or strapping code. Per CPT, only the physician who provides the follow-up care can bill for the fracture/ dislocation
EG	Legal cost bill - exceeds 30-day submission period	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	Legal cost bill - exceeds witness fee allowable	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
EI	IME charges billed by physician to SAIF in error	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	Record review with IME concurrence not payable	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	Record review with consultation not payable	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	Record review < 30 minutes not payable	Disallowed; requested record review of less than 30 minutes total duration is not separately report/billed per CPT.
EM	Legal cost bill - exceeds $1,500 maximum allowable	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	Legal cost bill - service does not qualify for reimbursement	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	Medication justification letters not payable	Disallowed; providing the justification for this medication is not reimbursable. Per OAR 436-009-0090, this information is required.
EP	Prolonged service < 30 minutes not payable	Disallowed; prolonged service less than 30 minutes total duration on a given date is not separately reported/billed per CPT guidelines.
ER	Review of provider's own records not payable	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	Surface EMGs not payable	Disallowed; surface EMGs are not payable per OAR 436-009-0010.
ET	Thermography not payable	Disallowed; thermography is not payable per OAR 436-009-0010.
EU	Unlisted CPT/HCPCS with no description	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
EX	X-ray copies not payable	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	Sep or addtl reading of x-rays not payable	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. Reimbursement of x-ray interpretation is only payable once.
FA	Missing or invalid NDC	Disallowed; NDC required for pharmaceutical service per OAR 436-009-0090 and OAR 436-009-0010 is missing or invalid.
FB	Adjusted for no-show or late cancel	Adjustment applied for no-show or late cancel. Per OAR 436-009-0010, no fee is payable for no show appointments other than arbiter, director required, independent medical, worker requested, or mandatory closing exams.
FC	Adjusted for physician assistant or nurse practitioner	Adjustment applied for physician assistant or nurse practitioner fees per OAR 436-009-0010.
FD	Late submission of bill over 12 months after DOS	Adjustment applied for late submission of bill per OAR 436-009-0010 and OAR 436-009-0110. Bills submitted over 12 months after the date of service are not payable.
FE	Required report, form, or copies not payable	Disallowed; report, form, or chart note copies are required per OARs 436-009-0010 & 436-009-0090.
FF	Missing, incorrect, or invalid service code	Disallowed; service code is missing, incorrect, or invalid per CPT, CDT, HCPCS, NDC or Oregon Administrative Rules.
FG	ASC DME/implant reduced per invoice	Adjustment applied to DME or implant per OAR 436-009-0023.
FH	Multiple CAT/CTA/MRA/MRI studies subject to 100/75 payment	Adjustment applied to reflect multiple CAT/CTA/MRA/MRI studies within two days per OAR 436-009-0040.
FI	Adjusted to reflect surgical or post-operative care only	Adjustment applied to reflect the fee schedule for rendering surgical or post-operative care only per CPT.

FJ	Physical medicine 3-code daily max	Disallowed; service exceeds physical medicine 3-code daily maximum per OAR 436-009-0040.
FL	Surgical/ASC procedure subject to 100/50 payment	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-surgery; reduced 25% per OAR or per billing agreement	Co-surgeons/two surgeons; 25% reduction per OAR 436-009-0040 or per provider's billing agreement.
FN	Worker reimbursement request exceeds two years	Disallowed; worker reimbursement exceeds two years and is not timely per OAR 436-009-0025.
FO	20% of primary surgeon payment for MD surgical assist	Adjustment applied for MD surgical assistant to 20% of primary surgeon's payment per OAR 436-009-0040.
FP	15% of primary surgeon payment for non-MD surg assist	Adjustment applied for physician assistant or nurse practitioner surgical assistance per OAR 436-009-0040.
FQ	10% of surgeon pymt for self-employed other surgical assist	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	X-ray findings not documented	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	HCPCS codes are required	Disallowed; HCPCS codes are required per OAR 436-009-0010.
FT	Audited per Oregon Medical Fee and Payment Rules	Fee schedule applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9).
FV	CPT 99058 not documented	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
FW	Appropriate documentation not attached	Disallowed; required documentation supporting the service/item billed is not attached per Oregon Administrative Rules. Billing must be resubmitted with supporting documentation.
FX	Hospital cost-charge ratio/fee schedule	Adjustment applied to reflect Hospital cost-charge ratio/fee schedule per OAR 436-009-0020.
FY	Sep. identifiable E/M service not documented	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	ASC implant cost not provided	Disallowed; ASC's implant cost required per 436-009-0023.
GA	Interpreter time not on billing	Disallowed; invoice does not include the total amount of time spent interpreting per OAR 436-009-0110.
GB	Interpreter's bill missing provider's name/address	Disallowed; invoice does not include the name and/or address of the medical provider per OAR 436-009-0110.
GC	Interpreter's name not on billing	Disallowed; invoice does not include the name of the interpreter per OAR 436-009-0110.
GD	Interpreter's starting address needed	Disallowed; interpreter mileage cannot be verifed. Starting address is needed per OARs 436-009-0110.

GE	Interpreter start/end times needed	Disallowed; total interpreter time cannot be verified. Start and end times are needed to determine reimbursement per OAR 436-009-0110.
GF	Prescription requires auth from physician	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	3-D imaging not documented	Disallowed; documentation does not support 3-D imaging was rendered. Per CPT, 2-D reformatting is not a separately reportable service.
GH	Independent workstation not documented	Disallowed; documentation does not support post-processing of 3-D rendering on an independent workstation.
GI	Independent trained observer not documented	Disallowed; documentation does not support an independent trained observer was present to monitor the patient's level of consciousness and physiological
GJ	99197 time not documented	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	99198 time not documented	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	Measurements not documented	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	Laboratory findings not documented	Disallowed; report of laboratory findings is required.
GO	Medical service does not support interpreter time	Adjustment applied per OAR 436-009-0110 to reflect treatment time documented by the medical provider. Clarification of additional interpreter time is needed.
GP	Psychotherapy time not documented	Disallowed; documentation does not indicate the face-to-face psychotherapy
GQ	Prolonged service time not documented	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	Record review time not documented	Disallowed; time spent reviewing the records or reports is not documented per OAR 436-009-0040.
GS	Missing or invalid MS-DRG code	Disallowed; missing or invalid MS-DRG code billed. The MS-DRG is required per OAR 436-009-0020.
GT	Testing of addtl body regions not documented	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	Regions treated not clearly identified	Disallowed; documenation does not clearly identify regions treated.
GV	Chiro notes not signed	Disallowed; each chart note entry must identify the provider of service per OAR 811-015-0005.
GW	Missing or invalid ICD-9	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	Invalid/Missing prescriber info, rx date, or cmpd indicator	Disallowed; missing prescriber name/NPI, missing date rx written, or invalid/missing compound indicator. Required per OAR 436-009-0010.
GY	Invalid/Missing admit code	Disallowed; invalid/missing admit code. Required per OAR 436-009-0010.
IA	Interpreter does not qualify for reimbursement	Disallowed; the person providing the interpreter services does not qualify for reimbursement per OARs 436-009-0005 and 436-009-0110.
IB	Adjusted for interpreter no-show or late cancel	Adjustment applied to reflect appropriate allowance for a no show/late cancel appointment per OAR 436-009-0110.
IC	Interpreter mileage not eligible for reimbursement	Disallowed; distance traveled by interpreter does not qualify for reimbursement per OARs 436-009-0110.
ID	Interpreter not payable if not for provider interp	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	Interpreter services & mileage only are payable	Disallowed; charge is not payable. Per OARs 436-009-0110, only interpreter services and mileage are reimbursable.
IF	Interpreter billing from medical provider not payable	Disallowed; an interpreter may only bill an insurer per OARs 436-009-0110. Interpreter billings submitted by medical providers are not payable.
IG	Overlapping interpreter time by the same interpreter	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	Home Health Plan not payable	Disallowed; physician certification of the patient's home health plan is not required for workers' compensation and was not requested.
II	Service not billed on OSC	Disallowed; service must be billed on appropriate Oregon Specific Code per OAR 436-009-0060.
IJ	Interpreter charges for consecutive appointments	Adjustment is applied to reflect total interpreter time for consecutive appointments by the same interpreter.
IK	Interpreter service for non-MCO treatment	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	Multidisciplinary code billed by non-accredited provider	Disallowed; provider must be CARF or JCAHO accredited for reimbursement on multidisciplinary service codes per OAR 436-009-0060.
IN	Health insurance reimbursement not payable	Disallowed; services are not payable under ORS 656.313 and OAR 436-060-0190 which specifies circumstances for health insurance reimbursement.
IP	Prepayments not payable	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.
IR	Non-physician service billable on EM service level	Disallowed; non-physician service billable on EM service level 99211 only.
IS	Surgery Center equipment not payable	Disallowed; equipment directly related to the provision of the surgical procedure is included in the ASC facility fee per OAR 436-009-0225.
IT	Drug and alcohol testing not payable	Disallowed; drug/alcohol testing is not payable. The service may be payable by the employer.
IU	Treatment time < 8 minutes is not payable	Disallowed; treatment time less than 8 minutes is not payable for a time based physical medicine code per OAR 436-009-0040.

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IV	Reduced 50% to reflect anesthesia modifier	Adjustment is applied to reflect 50% reduction per anesthesia modifier QK, QX, or QY.
MA	MCO contract package price is reflected in allowance	Adjustment applied for MCO contract package price.
MC	MCO contract rate or discount	Adjustment applied to reflect MCO contract rate or discount. Direct inquiries/appeals to the MCO.
MD	MCO guidelines/certification/contract	Disallowed; audited to MCO guidelines/contract or unable to verify certification of services. Direct inquiries/appeals to the MCO.
ME	Service not payable per SAIF/MCO contract	Disallowed; service not payable per SAIF/MCO contract. Direct bills and inquiries/appeals to the MCO.
MG	Referring or treating provider not MCO enrolled	Disallowed; referring or treating provider not MCO enrolled and/or not enrolled in same MCO as claim.
MI	Information requested by MCO not payable	Disallowed; information requested by MCO is included in the MCO services. Direct inquiries to the MCO.
MJ	Visit exceeds MCO precerted visits	Disallowed; this visit is beyond the number of visits authorized per the MCO precertification. Direct inquiries/appeals to the MCO.
MK	CPT code not included in MCO precert	Disallowed; this CPT code is not included in the MCO precertification. Direct inquiries/appeals to the MCO.
NA	SAIF negotiated amount	Adjustment reflects SAIF negotiated amount.
NB	Billing adjustment	Billing adjustment applied.
ND	SAIF/provider agreement	Adjustment applied to reflect SAIF/provider agreement.
NE	Adjustment for overpayment	Adjustment applied to reflect an overpayment.
NF	Discount applied per OMFPR	Discount applied per the Oregon Medical Fee and Payment Rules (OAR 436 Division 9)
NG	Specific HCPCS required	Disallowed; unlisted HCPCS must not be used if a more specific code is available per OAR 436-009-0010.
NH	IME service billed on wrong code	Disallowed; service is not billed on the correct code per the IME contract.
NI	Adjusted per pharmacy invoice	Adjustment applied to reflect pharmacy invoice.
NV	Vaccine charge reduced for hospitals	Adjustment applied to reflect the usual fee by similar providers for the vaccine charge per OAR 436-009-0040.
PA	Service previously paid	Disallowed; service has been previously paid.
PB	Service previously audited to zero	Disallowed; service has been previously audited to zero.
PC	Service previously audited; pending pymt decision	Disallowed; service has been previously audited and is pending payment
PD	Adjusted to reflect rentals paid	Adjustment applied to reflect rentals paid.
PE	Maximum rentals paid; considered purchased	Disallowed; maximum rentals have been paid. The item is considered purchased.
PF	Paid in another SAIF claim	Disallowed; payment was made in another SAIF claim.
RA	Multiple claims treated during single visit	Adjustment applied to reflect multiple claims treated during a single visit.
RC	Documentation does not support service or item billed	Disallowed; documentation does not support the service or item billed.
RD	Injection/aspiration site and/or med not given	Disallowed; documentation does not identify injection site and/or medication/substance injected.

RE	Interim Medical Benefits	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	Insufficient documentation/information from injured worker	Disallowed; reimbursement request does not contain sufficient documentation/information as required by OAR 436-009-0025.
RG	Meal doesn't qualify for reimbursement	Disallowed; distance traveled does not qualify for meal reimbursement.
RH	Reduced to reflect allowance of worker's meal	Adjustment applied to reflect allowance of the worker's meal per OAR 436-009-0025.
RI	Need pharmacy rx slip	Disallowed; pending receipt of the pharmacy slip with the name of the physician, medication, date filled, and amount paid.
RJ	Need correct date of service	Disallowed; pending receipt of the correct date of service.
RK	Medical services and copays to worker not payable	Disallowed; medical services and copays are not reimbursable to the worker. Medical provider must bill SAIF and reimburse worker.
RL	Reduced or disallowed Lost Earnings	Reimbursement reduced or disallowed for Lost Earnings while attending a required medical exam.
RM	Ineligible and/or unreasonable expense	Disallowed; expense not eligible and/or reasonable for reimbursement per OAR 436-009-0025.
RO	Over-the-counter medication not payable	Disallowed; over-the-counter medications are not reimbursable unless specifically requested by the prescribing physician and approved by the claims adjuster.
RP	Form 4909 required - WR	Disallowed; this medication requires authorization from your physician.
RQ	Expense for future service not payable	Disallowed; reimbursement of expense is not payable until related service has occurred.
RR	Prescription requires auth from MCO	Disallowed; medication requires authorization from your Managed Care Organization (MCO).
SB	Allowance based on usual fees for this service	Allowance is based on the usual fees accepted by similar providers for this
SC	Service requested by the employer's/ worker's	Disallowed; service requested by the employer's or worker's attorney.
SD	Unusual service; payment was increased over fee schedule	Unusual services; the value/allowance for this service has been increased.
SE	Date of service occurred prior to date of injury	Disallowed; billing indicates date of service occurred prior to the date of injury.
SF	Payment made 50% for contralateral procedure same operation	Bilateral procedure; adjusted to 50% for second procedure at same operative session per OAR 436-009-0050.
SG	All or part of this service not authorized	Disallowed; SAIF Corporation has not authorized payment for all or part of this service.
SH	No record of medical service	Disallowed; SAIF has no record of a medical service occurring on this date.
SI	Charge for supply/service not normally billed or	Disallowed; charge for supply/service not normally billed or allowed.
SJ	Interest/service charge or late fee not payable	Disallowed; interest/service charges or late fees are not payable for medical services paid timely per OAR 436-009-0030.
SK	Medically inappropriate and/or unnecesary	Disallowed; medically inappropriate and/or unnecessary. OAR 436-010-230; ORS 656.245(4)(a).
SL	Charge appears unreasonable	Per OAR 436-009-0030, adjustment applied to reflect reasonable reimbursement for the service rendered.

SM	Length of stay exceeds acute care criteria	Disallowed; length of stay exceeds acute care criteria.
SO	Late filing of vocational bill	Adjustment applied to reflect late filing of vocational bill per Vocational Rehabilitation Service Agreement.
SP	Service needs apportionment	Disallowed; charges need to be apportioned. SAIF Corporation may not be responsible for a portion of the charge due to compensability.
SQ	Not submitted on completed required form	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	Documentation does not identify rendering provider	Disallowed; documentation does not identify the person providing the service as required per OAR 436-009-0010.
ST	Service previously audited to pharmacy network	Service previously audited to pharmacy network.
SU	Service appears to be billed to SAIF Corporation in	Disallowed; service appears to be billed to SAIF Corporation in error.
SV	Missing modifier SG	Disallowed; modifier SG is required to identify facility charges per OAR 436-009-0023.
SW	Not appealed within 90 days	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	D0019 IME review not requested by SAIF	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	Record review or report not requested by SAIF	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	Charge billed more than once	Disallowed; the charge was billed more than once.
TB	Service considered preventative, not treatment	Disallowed; the service is considered preventative, not treatment. The service may be payable by the employer.
TC	Tx plan not recvd, incomplete, untimely, or authorized	Disallowed; treatment plan is not received, was received untimely, was incomplete, and/or service was not authorized by the treatment plan per OAR
TD	Service not performed within provider's medical license	Disallowed; service was not performed within provider's medical license per OAR 436-009-0010.
TE	Palliative care not authorized or exceeds authorization	Disallowed; palliative care not authorized or exceeds authorization per OAR 436-010-0290.
TF	Hearing test not by licensed audiologist/otolaryngoloist	Disallowed; testing for hearing aids must be done by a licensed audiologist/otolaryngologist per OAR 436-009-0080.
TG	Hearing aids not authorized	Disallowed; hearing aid(s) not authorized per OAR 436-009-0080.
TH	CPT code not a timed code	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 per attending physician status; 12/30 and 18/60	Disallowed; attending physician status per OAR 436-010-0005 and/or referral not documented.
TJ	Service not authorized by attending physician	Disallowed; service not authorized by attending physician per OAR 436-010-0220, attending physician status per OAR 436-010-0005, or referral not

TK	Service not reimbursable per CPT and/or OARs	Disallowed; service not reimbursable per CPT guidelines and/or Oregon Administrative Rules.
TL	Practitioner not subject to reimbursement as surgical asst	Disallowed; this practitioner is not subject to reimbursement as a surgical assistant.
TN	Documentation is not legible	Disallowed; attached documentation is illegible. Per OARs 436-009-0010 and 436-010-0240, the documentation must be legible.
TO	Unable to pay without itemized charges	Disallowed; itemization of all charges is needed for reimbursement. Billing must be resubmitted with itemized charges.
TQ	Not done with direct control/supervision of attend physician	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-
TR	Treatment is unscientific/unproven/outmoded/experimental	Disallowed; medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental per OAR 436-010-0300.
TS	Billing entity not med service provider or health insurer	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	Invalid or missing place of service code	Disallowed; invalid or missing place of service code.
TV	Creams/gels/ointments/lotions/sprays not payable	Disallowed; non-prescription topical creams, gels, ointments, lotions, or sprays are not reimbursable.
TW	CPT 72010 lateral views not payable	Adjustment applied for CPT 72010. Per OAR 436-009-0040(4), 14" x 36" lateral views are not payable.
TX	Medication - not the initial supply	Disallowed; medication dispensed is not the initial supply as required per OAR 436-010-0230. Initial supply means the medication is dispensed on the initial date of treatment.
TY	Provider not authorized/certified	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	CPTs 97010 - 97028 not timed codes	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
WA	LHWCA limits payment for chiropractic services	Disallowed; Longshore and Harbor Workers' Compensation (LHWCA) limits reimbursement for chiropractic services to correct a subluxation of the spine (20 CFR 702.404).
WB	Adjusted per external audit review	Adjustment applied per external audit review.
WC	Adjusted to state fee schedule of rendering provider	Adjustment applied to reflect the rendering provider's state fee schedule.
WG	Worker withdrawing claim	Disallowed; the injured worker withdrew their claim. Please contact the worker to determine how to proceed.
XA	CPT 64550 corrected to CPT 97014	The audit reflects the correct code of CPT 97014 for subsequent application of a TENS/MENS unit.
XB	D0010 code corrected	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	D0030 Insurer phone consult code corrected	Per OAR 436-009-0070, 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	SAIF claim number corrected	The SAIF claim number billed is incorrect. Explanation of Benefits reflects the correct claim number.
ZD	Date of service corrected	Date(s) of service corrected to reflect documentation.
ZE	Closing exam; non-disabling claim	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	Closing exam; claim not closed	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; claim already closed	A closing exam was previously performed and the claim was already closed. Appropriate reimbursement is made on the documented E/M level of service.
ZH	Closing exam code corrected	The audit reflects the correct code for a closing exam.
ZI	D0019 IME review and response code corrected	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	Report code corrected	The audit reflects the correct report code.
ZK	Service code reduced to reflect nature of injury	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	Level of service reduced per documentation	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 corrected	Manipulation code is reduced to reflect treatment of condition(s) related to this claim.
ZN	CPTs 97112/97532-97537 code corrected	The severity of the worker's injury does meet the criteria for the code billed. The audit reflects the appropriate code per CPT guidelines.
ZO	Incorrect, obsolete or invalid code corrected	The code billed is incorrect, obsolete or invalid. The audit reflects the correct
ZP	PT/OT evaluation changed to re-evaluation	The audit reflects a re-evaluation since an initial evaluation has already been performed.
ZQ	New visit/consult corrected to established patient	The audit reflects an established patient visit.
ZR	R0001; number of copies not given	Reimbursement is made for one record copy since billing does not indicate the number of copies provided.
ZS	R0001/R0002; correct codes for copies of medical records	Per OAR 436-009-0060, Oregon Specific code R0001 is for copies of requested medical records and Oregon Specific Code R0002 is for electronic copies of requested medical records.
ZT	IME code corrected	The audit reflects the correct IME code.
ZU	HCPCS code corrected to CPT code or OSC	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 changed to reflect 10-day medication supply	Quantity has been changed for medication dispensed to reflect a maximum 10-day supply as required per OAR 436-010-0230.

ZW	Provider billing for MCO withhold	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.
ZX	Postage/Handling for sending x-ray copies	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	D0004 interpreter service code corrected	The audit reflects the correct code for interpreter services.
ZZ	D0041 interpreter mileage code corrected	The audit reflects the correct code for interpreter mileage.