



J. Provider Remittance Advice (RA) Codes

Section J.1 lists the Explanation of Benefit (EOB) and Adjustment Reason Codes that may appear on a Provider Remittance Advice (RA) for paid, denied, or adjusted claims.

J.1 Explanation of Benefit (EOB) Codes

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 0201 | INVALID PAY-TO PROVIDER NUMBER | 125 |
| 0203 | RECIPIENT I.D. NUMBER MISSING | 16 |
| 0206 | PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT | 16 |
| 0208 | PREGNANCY INDICATOR INVALID | 45 |
| 0210 | BRAND MEDICALLY NECESSARY INDICATOR INVALID | 125 |
| 0211 | INVALID REFILL INDICATOR VALUE | 16 |
| 0212 | MISSING PRESCRIPTION NUMBER | 16 |
| 0213 | DATE PRESCRIBED IS MISSING | B17 |
| 0214 | DATE PRESCRIBED IS INVALID | B17 |
| 0215 | DATE DISPENSED IS MISSING | 16 |
| 0216 | DATE DISPENSED IS INVALID | 16 |
| 0217 | MISSING DRUG CODE | 16 |
| 0218 | INVALID DRUG CODE | 16 |
| 0219 | QUANTITY DISPENSED IS MISSING | 16 |
| 0220 | QUANTITY DISPENSED IS INVALID | 16 |
| 0221 | MISSING DAYS SUPPLY | 16 |
| 0222 | ESTIMATED DAYS SUPPLY INVALID | 45 |
| 0223 | MISSING DIAGNOSIS INDICATOR | 16 |
| 0224 | DIAGNOSIS TREATMENT INDICATOR INVALID | 16 |
| 0225 | REFERRING PROVIDER - INVALID FORMAT | 16 |
| 0226 | ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER | 16 |
| 0227 | THIRD PARTY PAYMENT AMOUNT INVALID | 16 |
| 0233 | UNITS OF SERVICE MISSING | 16 |
| 0234 | PROCEDURE CODE MISSING | 16 |
| 0235 | PROCEDURE CODE NOT IN VALID FORMAT | 16 |
| 0239 | DETAIL TO DATE OF SERVICE IS MISSING | 16 |
| 0240 | THE DETAIL TO" DATE IS INVALID " | 16 |
| 0242 | SECONDARY DIAGNOSIS CODE INVALID | 47 |
| 0243 | MISSING MEDICARE PAID DATE | 17 |
| 0244 | THIRD DIAGNOSIS CODE INVALID | 47 |
| 0246 | FOURTH DIAGNOSIS CODE INVALID | 47 |
| 0247 | MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED | 16 |
| 0248 | PLACE OF SERVICE IS MISSING OR BLANK | 129 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|--|-------------------------------|
| 0249 | PLACE OF SERVICE IS INVALID | 129 |
| 0250 | CLAIM HAS NO DETAILS | 16 |
| 0251 | FIRST MODIFIER INVALID FOR DATE OF SERVICE | 4 |
| 0252 | SECOND MODIFIER INVALID FOR DATE OF SERVICE | 4 |
| 0253 | THIRD MODIFIER INVALID FOR DATE OF SERVICE | 4 |
| 0258 | MISSING DIAGNOSIS CODE | 16 |
| 0260 | UNITS OF SERVICE NOT IN VALID FORMAT | 16 |
| 0261 | MISSING TOOTH NUMBER | 16 |
| 0262 | INVALID TOOTH NUMBER | 16 |
| 0263 | INVALID TOOTH SURFACE | 16 |
| 0264 | DETAIL FROM DATE OF SERVICE IS MISSING | 16 |
| 0265 | DETAIL FROM DATE OF SERVICE IS INVALID | 16 |
| 0266 | MISSING TOOTH SURFACE | 16 |
| 0268 | BILLED AMOUNT INVALID | 16 |
| 0269 | DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT | 16 |
| 0270 | MISSING TOTAL CLAIM CHARGE | 16 |
| 0271 | INVALID TOTAL CLAIM CHARGE | 16 |
| 0272 | PRIMARY DIAGNOSIS CODE INVALID | 47 |
| 0273 | TYPE OF BILL MISSING | 16 |
| 0274 | TYPE OF BILL CODE INVALID | 16 |
| 0275 | ADMIT DATE MISSING | 16 |
| 0276 | ADMIT DATE INVALID | 16 |
| 0277 | INVALID ADMISSION HOUR | 16 |
| 0278 | ADMIT TYPE MISSING | 129 |
| 0279 | INVALID TYPE OF ADMISSION | 16 |
| 0280 | PATIENT STATUS IS MISSING | 129 |
| 0281 | PATIENT STATUS IS INVALID | 129 |
| 0282 | MISSING COVERED DAYS | 16 |
| 0283 | COVERED DAYS INVALID | 16 |
| 0284 | PRIMARY CONDITION CODE INVALID | 16 |
| 0285 | SECOND CONDITON CODE INVALID | 16 |
| 0286 | THIRD CONDITION CODE INVALID | 16 |
| 0287 | FOURTH CONDITION CODE INVALID | 16 |
| 0288 | FIFTH CONDITION CODE INVALID | 16 |
| 0289 | SIXTH CONDITION CODE INVALID | 16 |
| 0290 | SEVENTH CONDITION CODE INVALID | 16 |
| 0295 | DATE FOR PRIMARY OCCURRENCE CODE MISSING | 16 |
| 0296 | DATE FOR PRIMARY OCCURRENCE CODE INVALID | 16 |
| 0297 | DATE FOR SECOND OCCURRENCE CODE MISSING | 16 |
| 0298 | DATE FOR SECOND OCCURRENCE CODE INVALID | 16 |
| 0299 | DATE FOR THIRD OCCURRENCE CODE MISSING | 16 |
| 0300 | DATE FOR THIRD OCCURRENCE CODE INVALID | 16 |
| 0301 | DATE FOR FOURTH OCCURRENCE CODE MISSING | 16 |
| 0302 | DATE FOR FOURTH OCCURRENCE CODE INVALID | 16 |
| 0339 | REVENUE CODE IS MISSING | 16 |
| 0340 | REVENUE CODE IS INVALID | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 0350 | THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT. | 16 |
| 0355 | FIFTH DIAGNOSIS CODE INVALID | 47 |
| 0356 | SIXTH DIAGNOSIS CODE INVALID | 47 |
| 0357 | SEVENTH DIAGNOSIS CODE INVALID | 47 |
| 0358 | EIGHTH DIAGNOSIS CODE INVALID | 47 |
| 0359 | NINTH DIAGNOSIS CODE INVALID | 47 |
| 0360 | ADMITTING DIAGNOSIS MISSING | 47 |
| 0361 | ADMITTING DIAGNOSIS CODE INVALID | 47 |
| 0364 | PRINCIPAL ICD9 PROCEDURE DATE MISSING | 16 |
| 0365 | PRINCIPAL ICD9 PROCEDURE DATE INVALID | 16 |
| 0367 | FIRST OTHER ICD9 PROCEDURE DATE MISSING | 16 |
| 0368 | FIRST OTHER ICD9 PROCEDURE DATE INVALID | 16 |
| 0370 | SECOND OTHER ICD9 PROCEDURE DATE MISSING | 16 |
| 0371 | SECOND OTHER ICD9 PROCEDURE DATE INVALID | 16 |
| 0373 | THIRD OTHER ICD9 PROCEDURE DATE MISSING | 16 |
| 0374 | THIRD OTHER ICD9 PROCEDURE DATE INVALID | 16 |
| 0376 | FOURTH OTHER ICD9 PROCEDURE DATE MISSING | 16 |
| 0377 | FOURTH OTHER ICD9 PROCEDURE DATE INVALID | 16 |
| 0379 | FIFTH OTHER ICD9 PROCEDURE DATE MISSING | 16 |
| 0380 | FIFTH OTHER ICD9 PROCEDURE DATE INVALID | 16 |
| 0381 | ATTENDING PHYSICIAN PROVIDER NUMBER MISSING | 16 |
| 0395 | HEADER STATEMENT COVERS PERIOD FROM" DATE MISSING " | 16 |
| 0396 | HEADER STATEMENT COVERS PERIOD FROM" DATE INVALID " | 16 |
| 0397 | HEADER STMT COVERS PERIOD THROUGH" DATE MISSING " | 16 |
| 0398 | STATEMENT COVERS PERIOD THROUGH" DATE INVALID " | 16 |
| 0400 | DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO | 16 |
| 0411 | DATE FOR FIFTH OCCURRENCE CODE MISSING | 16 |
| 0412 | DATE FOR FIFTH OCCURRENCE CODE INVALID | 16 |
| 0413 | DATE FOR SIXTH OCCURRENCE CODE MISSING | 16 |
| 0414 | DATE FOR SIXTH OCCURRENCE CODE INVALID | 16 |
| 0415 | DATE FOR SEVENTH OCCURRENCE CODE MISSING | 16 |
| 0416 | DATE FOR SEVENTH OCCURRENCE CODE INVALID | 16 |
| 0417 | DATE FOR EIGHTH OCCURRENCE CODE MISSING | 16 |
| 0418 | DATE FOR EIGHTH OCCURRENCE CODE INVALID | 16 |
| 0433 | MEDICARE DEDUCTIBLE AMOUNT INVALID | 2 |
| 0434 | MEDICARE COINSURANCE AMOUNT INVALID | 2 |
| 0436 | TOTAL MEDICARE ALLOWED AMOUNT INVALID | 62 |
| 0450 | INVALID QUADRANT | 11 |
| 0450 | INVALID QUADRANT | |
| 0455 | DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED | 16 |
| 0456 | INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|--|-------------------------------|
| 0457 | INVALID PRINCIPAL/OTHER PROCEDURE TYPE | 16 |
| 0458 | THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT | 47 |
| 0465 | DATE FOR OCCURRENCE CODE 9-24 MISSING | 16 |
| 0466 | DATE FOR OCCURRENCE CODE 9-24 INVALID | 16 |
| 0471 | CONDITION CODE 8-24 INVALID | 16 |
| 0474 | ICD9 PROCEDURE 7-24 OR DATE MISSING | 16 |
| 0475 | ICD9 PROCEDURE 7-24 DATE INVALID | 16 |
| 0500 | DATE PRESCRIBED AFTER BILLING DATE | 125 |
| 0502 | DATE DISPENSED EARLIER THAN DATE PRESCRIBED | 45 |
| 0503 | DATE DISPENSED AFTER BILLING DATE | 110 |
| 0505 | NO PAYMENT MADE-TPL IS MORE THAN THE ALLOWED AMOUNT. | 30 |
| 0507 | FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV | 16 |
| 0508 | TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS | 16 |
| 0512 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 |
| 0513 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION | 16 |
| 0514 | DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV | 16 |
| 0519 | ADMIT DATE GREATER THAN FIRST DATE OF SERVICE | 110 |
| 0526 | DETAIL DATES NOT WITHIN HEADER DATES | 16 |
| 0527 | DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE | 16 |
| 0529 | SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE | 129 |
| 0530 | SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE | 129 |
| 0537 | HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE | 125 |
| 0555 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 |
| 0556 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 |
| 0570 | TOTAL DAYS LESS THAN COVERED DAYS | 16 |
| 0571 | SURGICAL PROCEDURE MISSING | 16 |
| 0573 | TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN | 16 |
| 0574 | SERVICE DATES ARE NOT IN SAME MONTH | 16 |
| 0575 | SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE | 16 |
| 0589 | ADJUSTMENT HAS AUTO DENIAL | 45 |
| 0595 | MANUALLY SUSPEND FOR REVIEW | 45 |
| 0596 | FILE SEPARATE CLAIMS FOR DIFFERENT YEARS | 129 |
| 0602 | UNITS NOT EQUAL TO TEETH BILLED | 16 |
| 0606 | MISSING OR INVALID PAYER DATE | 125 |
| 0643 | INVALID OTHER COVERAGE CODE | 45 |
| 0675 | ADJ - RECIPIENT ID NOT SUBMITTED | 16 |
| 0676 | ADJ - PROVIDER ID NOT SUBMITTED | 16 |
| 0677 | ADJ - ORIGINAL ICN NOT FOUND | 16 |
| 0678 | ADJ - ORIGINAL ICN NOT SUBMITTED | 16 |
| 0679 | ADJ - REQUEST RECIPIENT ID NOT FOUND | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 0680 | ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL | 16 |
| 0681 | ADJ - ORIGINAL ICN NOT FOUND | 16 |
| 0682 | ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED | 16 |
| 0683 | ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS | 16 |
| 0684 | ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL | 16 |
| 0685 | ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS | 16 |
| 0800 | DETAIL RATE NOT NUMERIC | 125 |
| 0801 | DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT | 125 |
| 0802 | MISSING OR INVALID PRESCRIBER ID QUALIFIER | 16 |
| 0803 | DATED EXCEED SOBRA/QMB ELIGIBILITY | 141 |
| 0804 | BILLING PROVIDER CANNOT BE PRESCRIBER | 52 |
| 0805 | NONCOVERED CHARGE IS NOT NUMERIC | 125 |
| 0806 | MEDICARE PAID AMOUNT MISSING OR INVALID | 125 |
| 0807 | INVALID TPL ADJUDICATION DATE | 16 |
| 0808 | TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE | 16 |
| 0809 | VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS | 16 |
| 0810 | INVALID DEDUCTIBLE AMT - SKILLED NURSING FACILITY | 125 |
| 0811 | HEADER FROM DATE OF SERVICE > ICN DATE | 125 |
| 0812 | ADMIT DATE IS GREATER THAN ICN DATE | 125 |
| 0813 | MEDICARE PAID DATE > ICN DATE | 16 |
| 0814 | DETAIL TO DATE OF SERVICE > ICN DATE | 125 |
| 0815 | SURGICAL ICD9 REQUIRES OPERATING PHYSICIAN | 125 |
| 0816 | COINSURANCE DAYS NOT NUMERIC | 2 |
| 0817 | INVALID COINSURANCE DAYS | 2 |
| 0818 | LIFETIME RESERVE DAYS NOT NUMERIC | 125 |
| 0819 | LIFETIME RESERVE DAYS > MAX ALLOWED | 125 |
| 0820 | FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR | 125 |
| 0821 | NON-COVERED DAYS MISSING OR NOT NUMERIC | 125 |
| 0822 | SURGICAL REVENUE CODE REQUIRES ICD9 SURGERY CODE | 125 |
| 0823 | RECIPIENT CHECK DIGIT IS MISSING OR INVALID | 125 |
| 0824 | UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION | B5 |
| 0825 | MEDICARE ALLOWED AMOUNT MISSING OR INVALID | 125 |
| 0826 | TYPE OF BILL INVALID FOR CLAIM TYPE | 16 |
| 0827 | NON COVERED AMOUNT IS GREATER THAN COVERED AMOUNT | 125 |
| 0829 | DAYS SUPPLY > 3 FOR EMERGENCY PHARMACY CLAIM | 57 |
| 0830 | MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW | 125 |
| 0831 | MEDICARE HDR PAID AMNT NOT EQUAL SUM OF DTL PAID | 125 |
| 0832 | OTHER PAYER AMOUNT PAID QUALIFIER INVALID | 16 |
| 0833 | CO-INSURANCE AMOUNT DOES NOT BALANCE | 16 |
| 0835 | MEDICARE DATA NOT FOUND - FORMAT ERROR | 16 |
| 0900 | PROVIDER TYPE SPECIALITY GROUP NOT FOUND | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|--|-------------------------------|
| 0901 | GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE | 16 |
| 0902 | PROCEDURE CODE GROUP NOT FOUND | 16 |
| 0903 | GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T | 16 |
| 0904 | GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE | 16 |
| 0905 | GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL | 16 |
| 0906 | GROUP NUMBER NOT FOUND IN ICD-9 GROUP TABLE | 16 |
| 0907 | GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE | 16 |
| 0909 | GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE | 16 |
| 0910 | BENEFIT PLAN GROUP NOT FOUND | 16 |
| 0911 | INTERNAL PROCESSING ERROR - CONTACT EDS | 16 |
| 0912 | INTERNAL ERROR-DOLLAR DISTRIBUTION | 16 |
| 0913 | GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE | 16 |
| 0914 | GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE | 16 |
| 0915 | GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE | 16 |
| 0916 | GROUP NOT FOUND IN PROVIDER GROUP TABLE | 16 |
| 0917 | GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE | 16 |
| 0918 | TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR | 16 |
| 0919 | GROUP NUMBER NOT FOUND IN AID CODE TABLE | 16 |
| 0920 | DRUG THERAPEUTIC CLASS GROUP NOT FOUND | 16 |
| 0921 | GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE | 16 |
| 0922 | TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE | 16 |
| 0923 | RULE OVERLAP IDENTIFIED | 16 |
| 1000 | NO PAY-TO PROVIDER RECORD | 16 |
| 1001 | BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE | B7 |
| 1002 | PERFORMING PROV NOT ELIGIBLE FOR DOS | 52 |
| 1003 | PROVIDER INELIGIBLE ON DATE OF SERVICE | 52 |
| 1007 | RENDERING PROVIDER IDENTIFIER NOT ON FILE | 16 |
| 1010 | PERFORMING PROVIDER NOT IN BILLING GROUP | 38 |
| 1018 | CLINIC RATE NOT ON FILE FOR HOSPITAL | 16 |
| 1020 | ATTENDING PHYSICIAN ID NOT ON FILE | 52 |
| 1021 | OTHER-1 (OPERATING) PROVIDER ID NOT ON FILE - HDR | 52 |
| 1024 | BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV | 45 |
| 1026 | PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE | 52 |
| 1032 | PROVIDER TYPE - CLAIM INPUT CONFLICT | 62 |
| 1048 | PERFORMING PROVIDER ENROLLMENT STATUS INVALID | 52 |
| 1049 | BILLING PROVIDER ENROLLMENT STATUS INVALID | B7 |
| 1051 | RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR) | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 1065 | PROVIDER NAME MISMATCH | 125 |
| 1803 | BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER | 125 |
| 1804 | VERFIY PERFORMING PROVIDER NOT GROUP PROVIDER | 125 |
| 1805 | BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS | 125 |
| 1806 | EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS UNDER | 6 |
| 1807 | CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE | 16 |
| 1808 | REFERRING PROVIDER IS MISSING OR NOT ON FILE | 52 |
| 1809 | REFERRING PROVIDER-NO SCREENING SPECIALTY FOR DOS | 52 |
| 1812 | RECIPIENT / ADMIT AGE GREATER THAN 21 | 6 |
| 1813 | PROVIDER SUSPENDED FOR OUTSTANDING CREDIT BALANCE | 52 |
| 1814 | BILLING PROVIDER NOT VALID FOR DATES OF SERVICE | B7 |
| 1816 | MATERNITY CARE MUST BE PERFORMED BY DISTRICT PROV | 109 |
| 1817 | MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS | 4 |
| 1818 | WAIVER PROVIDER MISMATCH | B7 |
| 1819 | INVALID POS FOR FQHC PROVIDER | 5 |
| 1820 | PATIENT FIRST CLAIM REQUIRES A REFERRAL | 38 |
| 1821 | MEDICAL LOCKIN - RECIPIENT LOCKED IN TO OTHER PROVIDER | |
| 1822 | MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES | |
| 1823 | WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES | |
| 1824 | LTC ASSIGNMENT DATES OVERLAP CLAIM DATES | |
| 1825 | COBA DENIAL - DO NOT CROSSOVER | 16 |
| 1900 | TAXONOMY IS INVALID BILLING PROVIDER | 45 |
| 1901 | TAXONOMY IS INVALID PREFORMING PROVIDER | 45 |
| 1906 | TAXONOMY IS NOT VALID FOR BILLING PROVIDER | 45 |
| 1907 | TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER | 45 |
| 1912 | TAXONOMY IS MISSING: BILLING PROVIDER | 45 |
| 1913 | TAXONOMY IS MISSING: PERFORMING PROVIDER | 45 |
| 1919 | TAXONOMY IS INVALID: DTL PERFORMING PROVIDER | 45 |
| 1921 | TAXONOMY IS MISSING: DTL PERFORMING PROVIDER | 45 |
| 1925 | TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV | 45 |
| 1927 | NPI REQUIRED HEALTHCARE=Y BILLING PROV | 45 |
| 1928 | NPI REQUIRED HEALTHCARE=Y PREMING PROV | 45 |
| 1931 | NPI REQUIRED HEALTHCARE=Y RENDERING PROV | 45 |
| 1934 | DTL NPI REQUIRED HEALTHCARE=Y PREMING PROV | 45 |
| 1936 | INVALID BILLING PROVIDER SPECIFIED | 47 |
| 1937 | INVALID PREFORMING PROVIDER SPECIFIED | 47 |
| 1938 | INVALID REFERRING PROVIDER SPECIFIED | 47 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 1939 | INVALID FACILITY PROVIDER SPECIFIED | 47 |
| 1940 | INVALID RENDERING PROVIDER SPECIFIED | 47 |
| 1941 | INVALID OTHER PROVIDER SPECIFIED | 47 |
| 1942 | INVALID DTL OTHER PROVIDER SPECIFIED | 47 |
| 1943 | INVALID DTL PREFORMING PROVIDER SPECIFIED | 47 |
| 1944 | INVALID DTL REFERRING PROVIDER SPECIFIED | 47 |
| 1945 | MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER | 47 |
| 1946 | MULT SAK PROV LOCS FOR PREFORMING PROV SPEC | 47 |
| 1949 | MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER | 47 |
| 1952 | MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER | 47 |
| 1960 | NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE) | 16 |
| 1961 | NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE) | 16 |
| 1995 | MMIS FACILITY PROVIDER ID NOT ENROLLED | 52 |
| 1996 | THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM. | B7 |
| 1999 | PROVIDER ID IS INVALID, IS NOT ON FILE OR NAME/NUMBER DISAGREE. | 92 |
| 2001 | RECIPIENT IS NOT ON ELIGIBILITY FILE | 30 |
| 2002 | RECIPIENT NOT ELIGIBLE FOR HEADER DATE OF SERVICE | 30 |
| 2003 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN | 141 |
| 2009 | RECIPIENT INELIGIBLE ON DATE OF SERVICE | 30 |
| 2045 | ITEM NOT PAYABLE IN LONG TERM CARE FACILITY | 100 |
| 2054 | UNABLE TO DETERMINE FUND CODE - DETAIL | 16 |
| 2057 | RECIPIENT PARTIALLY ELIGIBLE - HEADER | B5 |
| 2077 | RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES | 141 |
| 2500 | RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT) | 109 |
| 2501 | RECIPIENT COVERED BY MEDICARE A (WITH ATTACHMENT) | 109 |
| 2502 | RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT) | 109 |
| 2503 | RECIPIENT COVERED BY MEDICARE B (WITH ATTACHMENT) | 109 |
| 2504 | FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER | 129 |
| 2505 | RECIPIENT COVERED BY PRIVATE INSURANCE (W/ATTACHMENT) | 129 |
| 2507 | THIS PATIENT HAS TWO COVERAGE TYPES | 22 |
| 2508 | RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY) | 129 |
| 2550 | RECIPIENT ENROLLED IN MEDICARE ADVANTAGE PLAN | 109 |
| 2590 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 |
| 2591 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 |
| 2603 | RECIPIENT LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER | 52 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 2800 | STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | 17 |
| 2801 | HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | 17 |
| 2802 | ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | 17 |
| 2804 | DETAILS COVERED BY MORE THAN ONE PLAN CODE | 141 |
| 2805 | DOS PRIOR TO DOB | 14 |
| 2806 | PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX | 6 |
| 2800 | STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | |
| 2801 | HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | |
| 2802 | ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | |
| 3000 | PCS PRIOR AUTHORIZATION UNITS USED | 62 |
| 3001 | PA NOT FOUND ON DATABASE | 62 |
| 3002 | NDC REQUIRES PA | 62 |
| 3003 | PROCEDURE REQUIRES PRIOR AUTHORIZATION | 62 |
| 3006 | PRIOR AUTH UNITS/AMOUNTS USED | 62 |
| 3019 | PA CUTBACK PERFORMED | 92 |
| 3100 | CLAIM AND PA PRESCRIBING PROV DON'T MATCH | 6 |
| 3101 | ONLINE PA DENIED BY HID, NDC REQUIRES PA | 6 |
| 3102 | ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM | 6 |
| 3103 | ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS | 6 |
| 3104 | PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES | 16 |
| 3300 | NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH | B5 |
| 3301 | BILL EMERGENCY PROCEDURE/REVENUE TOGETHER | |
| 3302 | PROCEDURE AND REVENUE CODE COMBINATION NOT VALID | B5 |
| 3303 | MEDICARE PAID AMOUNT EQUAL 100% | 42 |
| 3304 | NON-COVERED SVC FOR RECIPIENT < 6 MONTHS OLD | 6 |
| 3305 | NO BASE VALUE FOR ANESTHESIA | |
| 3306 | HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT | 125 |
| 3307 | FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT | B5 |
| 3308 | PROCEDURE CODE/MODIFIER NOT ON RATE FILE | |
| 3309 | PROCEDURE CODE - TYPE OF BILL RESTRICTION | 16 |
| 3310 | DISPENSING FEE NOT LOCATED | 16 |
| 3311 | REFILL NUMBER EXCEEDS MAXIMUM ALLOWED | B5 |
| 3312 | DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY | 62 |
| 3313 | NDC DRUG, PRODUCT IS NOT PREFERRED | 62 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 3314 | PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP | B5 |
| 3315 | NURSERY DAYS EXCEED LIMIT | 16 |
| 3316 | PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDI | 16 |
| 3317 | CLAIM QUANTITY EXCEEDS NDC MAX UNITS | |
| 3599 | MANUAL PRICING REQUIRED | 101 |
| 3800 | SERVICE COVERAGE HAS NOT BEEN DETERMINED | 16 |
| 3998 | BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 3999 | BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4001 | BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4002 | BPA-RP-NDC - NO COVERAGE | 16 |
| 4004 | NDC IS NOT ON FILE | 96 |
| 4013 | PROCEDURE CODE IS NO LONGER VALID | 96 |
| 4014 | NO PRICING SEGMENT IS ON FILE. | 133 |
| 4016 | BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4021 | BPA-RP-PROC - NO COVERAGE | 16 |
| 4023 | BPA-RP-NDC - GENDER RESTRICTION | 16 |
| 4025 | BPA-RP-NDC - AGE RESTRICTION | 16 |
| 4026 | BPA-RP-NDC - MAX UNIT RESTRICTION | 16 |
| 4027 | DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE | 92 |
| 4028 | BPA-RP-DIAG - GENDER RESTRICTION | 16 |
| 4029 | BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION | 16 |
| 4030 | BPA-RP-DIAG - AGE RESTRICTION | 16 |
| 4031 | BPA-PC-DIAG - GENDER RESTRICTION | 16 |
| 4032 | PROCEDURE CODE IS MISSING/NOT ON FILE | 96 |
| 4034 | BPA-RP-PROC - AGE RESTRICTION | 16 |
| 4035 | BPA-RP-PROC - GENDER RESTRICTION | 16 |
| 4036 | BPA-RP-PROC - PLACE OF SERVICE RESTRICTION | 16 |
| 4040 | PRIMARY DIAGNOSIS CODE NOT ON FILE | 47 |
| 4041 | SECONDARY DIAGNOSIS CODE NOT ON FILE | 47 |
| 4042 | THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE | 47 |
| 4043 | FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE | 47 |
| 4044 | BPA-RR-DIAG - NO RULE FOR ASSOC AGE | 16 |
| 4045 | BPA-RR - NO RULE FOR BENEFIT PLAN | 16 |
| 4046 | DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE | 96 |
| 4047 | FIFTH DIAGNOSIS CODE NOT ON FILE | 47 |
| 4048 | SIXTH DIAGNOSIS CODE NOT ON FILE | 47 |
| 4049 | SEVENTH DIAGNOSIS CODE NOT ON FILE | 47 |
| 4050 | EIGHTH DIAGNOSIS CODE NOT ON FILE | 47 |
| 4051 | NINTH DIAGNOSIS CODE NOT ON FILE | 47 |
| 4052 | ADMITTING DIAGNOSIS CODE NOT ON FILE | 47 |
| 4059 | REVENUE CODE NOT ON FILE | 16 |
| 4061 | BPA-RR - NO RULE FOR CLAIM TYPE | 16 |
| 4062 | BPA-RR - NO RULE FOR COND CODE | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 4064 | BPA-RP-ICD9 - GENDER RESTRICTION | 16 |
| 4068 | BPA-RR - NO RULE CURR BILL PROV CONTRACT | 16 |
| 4070 | BPA-RR-PROC - MODIFIER RESTRICTION | 16 |
| 4072 | BPA-RR-DRG - NO RULE FOR ADMIT OR HDR DIAGNOSIS | 16 |
| 4073 | BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION | 16 |
| 4075 | BPA-RP-ICD9 - FAMILY PLANNING IND RESTRICTION | 16 |
| 4076 | BPA-RP-NDC - FAMILY PLANNING IND RESTRICTION | 16 |
| 4077 | NON-COVERED REVENUE CODE | 92 |
| 4093 | BPA-RP-DIAG - DIAG ROLE RESTRICTION | 16 |
| 4094 | BPA-PC-REV - PROV COUNTY RESTRICTION | 16 |
| 4104 | BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION | 16 |
| 4106 | BPA-RP-REV - FAMILY PLANNING IND RESTRICTION | 16 |
| 4109 | BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION | 16 |
| 4112 | BPA-PC-ICD9 - FAMILY PLANNING IND RESTRICTION | 16 |
| 4117 | BPA-PC-DRUG - FAMILY PLANNING IND RESTRICTION | 16 |
| 4118 | BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION | 16 |
| 4120 | ORAL CAVITY DESIGNATION CODE INVALID | 16 |
| 4127 | CANNOT PRIORITIZE RECIPIENT'S PROGRAMS | 133 |
| 4130 | PAYER HIERARCHY NOT FOUND | 63 |
| 4131 | NO BENEFIT PLANS ASSOCIATED TO PAYER | 63 |
| 4136 | BPA-RP-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4138 | BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4140 | BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4141 | BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4142 | BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4143 | BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4144 | BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4149 | BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4150 | BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4151 | BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4152 | BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 4154 | BPA-PC-REV - FAMILY PLANNING IND RESTRICTION | 16 |
| 4155 | BPA-RR-PROC - PLACE OF SERVICE RESTRICTION | 16 |
| 4157 | BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION | 16 |
| 4159 | BPA-PC-ICD9 - CURR PROV CONTRACT RESTRICTION | 16 |
| 4160 | BPA-PC-DRUG - CURR PROV CONTRACT RESTRICTION | 16 |
| 4161 | BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION | 16 |
| 4162 | BPA-PC-REV - CURR PROV CONTRACT RESTRICTION | 16 |
| 4164 | INACTIVE DRUG | 6 |
| 4166 | BPA-RR-DRUG - NO RULE FOR BENEFIT PLAN | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 4167 | BPA-RR-REV - NO RULE FOR BENEFIT PLAN | 16 |
| 4177 | BPA-PC-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4192 | BPA-RP-DRG - OTHER DTL DIAG RESTRICTION | 16 |
| 4200 | CLAIM PRICED AT ZERO | 92 |
| 4203 | DENIAL MODIFIER SUBMITTED ON CLAIM | B7 |
| 4207 | CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE | 100 |
| 4208 | CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD | 45 |
| 4210 | BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 |
| 4211 | INVALID TOOTH NUMBER FOR THIS PROCEDURE | 96 |
| 4212 | BILLING OUT OF CLIA CERTIFICATE TYPE | 5 |
| 4219 | BPA-RR-REV - NO RULE FOR TYPE OF BILL | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 4224 | BPA-RP-PROC - QUANTITY RESTRICTION | 16 |
| 4225 | INVALID INPATIENT REVENUE CODE | 16 |
| 4226 | DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION | 16 |
| 4227 | BPA-RP-REV - NO COVERAGE | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 4231 | BPA-PC-DRUG - MAX UNIT RESTRICTION | 16 |
| 4240 | THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE | 16 |
| 4244 | BPA-RP-DIAG - NO COVERAGE | 16 |
| 4245 | FOURTH MODIFIER INVALID FOR DATE OF SERVICE | 4 |
| 4246 | ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE | 45 |
| 4250 | BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF | 16 |
| 4251 | DECIMAL UNITS NOT BILLABLE FOR PROCEDURE. | 16 |
| 4252 | DIAGNOSIS CODE 10-24 NOT ON FILE | 16 |
| 4254 | BPA-RP-REV - AGE RESTRICTION | 16 |
| 4256 | BPA-RP-PROC - MODIFIER RESTRICTION | 16 |
| 4257 | BPA-PC-PROC - MODIFIER RESTRICTION | 16 |
| 4258 | BPA-PC-DRG - OCCURRENCE CODE RESTRICTION | 16 |
| 4310 | BPA-PC-PROC - ADMIT DIAG RESTRICTION | 16 |
| 4311 | BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4312 | BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION | 16 |
| 4313 | BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION | 16 |
| 4314 | BPA-RP-DIAG - CLAIM TYPE RESTRICTION | 16 |
| 4315 | BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION | 45 |
| 4316 | BPA-PC -ANY DTL DIAG RESTRICTION | 16 |
| 4317 | BPA-PC-ICD9 - ADMIT DIAG RESTRICTION | 16 |
| 4318 | BPA-PC-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4319 | BPA-PC-ICD9 - ANY HDR DIAGNOSIS RESTRICTION | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 4320 | BPA-PC-REV - ADMIT DIAG RESTRICTION | 16 |
| 4321 | BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4322 | BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 |
| 4361 | BPA - DIAGNOSIS RESTRICTION | 16 |
| 4362 | BPA-PC-DIAG - TYPE OF BILL RESTRICTION | 16 |
| 4364 | BPA-PC-ICD9 - TYPE OF BILL RESTRICTION | 16 |
| 4371 | BPA-RP-PROC - CLAIM TYPE RESTRICTION | 16 |
| 4372 | BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION | 16 |
| 4373 | BPA-RP-NDC - CLAIM TYPE RESTRICTION | 16 |
| 4374 | BPA-RP-REV - CLAIM TYPE RESTRICTION | 16 |
| 4376 | BPA-RP-ICD9 - CLAIM TYPE RESTRICTION | 16 |
| 4500 | BPA-RR-NDC - ALGI RESTRICTION | 16 |
| 4501 | BPA-RR-NDC - NO RULE FOR DISP AS WRITTEN IND | 16 |
| 4502 | BPA-RP-PROC - EPSDT REFERRAL RESTRICTION | 16 |
| 4503 | BPA-PC-PROC - EPSDT REFERRAL RESTRICTION | 16 |
| 4504 | BPA-RP-NDC - ALGI RESTRICTION | 16 |
| 4505 | BPA-RR-PROC - NO RULE FOR URBAN/RURAL IND | 16 |
| 4506 | BPA-PC-DIAG - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4508 | BPA-PC-PROC - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4509 | BPA-PC-REV - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4511 | BPA-RP-DIAG - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4514 | BPA-RP-PROC - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4515 | BPA-RP-REV - PERF PROV ALL PT/PS RESTRICTION | 16 |
| 4516 | BPA-PC-DIAG - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4517 | BPA-PC-DRUG - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4518 | BPA-PC-ICD9 - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4519 | BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4520 | BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4521 | BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4522 | BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4523 | BPA-RP-ICD9 - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4524 | BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4525 | BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION | 16 |
| 4526 | BPA-PC-PROC - PROV COUNTY RESTRICTION | 16 |
| 4527 | BPA-PC-DRUG - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4529 | BPA-RP-REV - PROV COUNTY RESTRICTION | 16 |
| 4530 | BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION | 16 |
| 4532 | BPA-RR-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4533 | BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4534 | BPA-RP-DRG - EMERGENCY DIAGNOSIS RESTRICTION | 16 |
| 4535 | BPA-RP-ICD9 - EMERGENCY DIAGNOSIS RESTRICTION | 16 |
| 4536 | BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION | 16 |
| 4538 | BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION | 16 |
| 4539 | BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION | 16 |
| 4540 | BPA-PC-PROC - MIN UNIT RESTRICTION | 16 |
| 4542 | BPA-RP-DRG - REFER PROV PRIMARY PT/PS | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| | RESTRICTION | |
| 4548 | BPA-PC-DRG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4554 | BPA-RR-DRG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4559 | BPA-RP-DRG - SECONDARY HDR DIAG RESTRICTION | 16 |
| 4560 | BPA-RP-ICD9 - SECONDARY HDR DIAG RESTRICTION | 16 |
| 4561 | BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION | 16 |
| 4562 | BPA-RP-REV - GENDER RESTRICTION | 16 |
| 4563 | BPA-RR - NO RULE CURR PERF PROV CONTRACT | 16 |
| 4564 | BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION | 16 |
| 4565 | BPA-RR-ICD9 - HDR SECONDARY DIAG RESTRICTION | 16 |
| 4566 | BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION | 16 |
| 4580 | BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP | 16 |
| 4581 | BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP | 16 |
| 4711 | BPA-PC-DIAG - AGE RESTRICTION | 16 |
| 4713 | BPA-PC-DRUG - AGE RESTRICTION | 16 |
| 4714 | BPA-PC-PROC - AGE RESTRICTION | 16 |
| 4715 | BPA-PC-REV - AGE RESTRICTION | 16 |
| 4716 | BPA-PC-ICD9 - AGE RESTRICTION | 16 |
| 4723 | BPA-RP-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4724 | BPA-RP-ICD9 - ANY HDR DIAGNOSIS RESTRICTION | 16 |
| 4726 | BPA-RP-ICD9 - ADMIT DIAG RESTRICTION | 16 |
| 4731 | BPA-RP-PROC - ANY DTL DIAG RESTRICTION | 16 |
| 4732 | BPA-RP-REV - ADMIT DIAG RESTRICTION | 16 |
| 4733 | BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 |
| 4736 | BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4741 | BPA-RP-PROC - ADMIT DIAG RESTRICTION | 16 |
| 4742 | BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 |
| 4743 | BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION | 16 |
| 4744 | BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION | 16 |
| 4745 | BPA-RP-PROC - DIAGNOSIS RESTRICTION | 16 |
| 4746 | BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION | 16 |
| 4747 | BPA-PC-ICD9 - HDR SECONDARY DIAG RESTRICTION | 16 |
| 4748 | BPA-PC-REV - HDR SECONDARY DIAG RESTRICTION | 16 |
| 4751 | BPA-PC-REV - TYPE OF BILL RESTRICTION | 16 |
| 4755 | BPA-PC-PROC - CURRENT BENEFIT PLAN RESTRICTION | 16 |
| 4756 | BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION | 16 |
| 4757 | BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 4762 | BPA-PC-ICD9 - PLACE OF SERVICE RESTRICTION | 16 |
| 4765 | BPA-RP-ICD9 - NO COVERAGE | 16 |
| 4766 | BPA-RP-ICD9 - AGE RESTRICTION | 16 |
| 4767 | BPA-RP-ICD9 - PLACE OF SERVICE RESTRICTION | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 4775 | BPA-PC-DRUG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4776 | BPA-PC-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 |
| 4801 | BPA-PC-PROC - NO CONTRACT | 16 |
| 4802 | BPA-PC-DIAG - NO CONTRACT | 16 |
| 4803 | BPA-PC-NDC - NO CONTRACT | 16 |
| 4804 | BPA-PC-REV - NO CONTRACT | 16 |
| 4806 | BPA-PC-ICD9 - NO CONTRACT | 16 |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | |
| 4821 | BPA-PC-PROC - PLACE OF SERVICE RESTRICTION | 16 |
| 4822 | BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION | 16 |
| 4831 | BPA-RR - NO REIMB RULE | 16 |
| 4835 | BPA-PC-PROC - OTHER DTL DIAG RESTRICTION | 16 |
| 4871 | BPA-PC-PROC - CLAIM TYPE RESTRICTION | 16 |
| 4872 | BPA-PC-DIAG - CLAIM TYPE RESTRICTION | 16 |
| 4873 | BPA-PC-DRUG - CLAIM TYPE RESTRICTION | 16 |
| 4874 | BPA-PC-REV - CLAIM TYPE RESTRICTION | 16 |
| 4876 | BPA-PC-ICD9 - CLAIM TYPE RESTRICTION | 16 |
| 4900 | BPA-RP-DIAG - BENE PLAN RESTRICTION | 16 |
| 4901 | BPA-RP-DIAG - CONDITION CODE RESTRICTION | 16 |
| 4902 | BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION | 16 |
| 4904 | BPA-RP-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4905 | BPA-RP-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4906 | BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4910 | BPA-PC-DIAG - BENEFIT PLAN RESTRICTION | 16 |
| 4911 | BPA-PC-DIAG - CONDITION CODE RESTRICTION | 16 |
| 4912 | BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION | 16 |
| 4913 | BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR | 16 |
| 4917 | BPA-PC-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4923 | BPA-PC-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4927 | BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4928 | BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4929 | BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4933 | BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4937 | BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4938 | BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4939 | BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4940 | BPA-RP-ICD9 - BENE PLAN RESTRICTION | 16 |
| 4941 | BPA-RP-ICD9 - CONDITION CODE RESTRICTION | 16 |
| 4942 | BPA-RP-ICD9 - OCCURRENCE CODE RESTRICTION | 16 |
| 4943 | BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4944 | BPA-PC-ICD9 - GENDER RESTRICTION | 16 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 4947 | BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4948 | BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4949 | BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION | 16 |
| 4950 | BPA-PC-ICD9 - BENEFIT PLAN RESTRICTION | 16 |
| 4951 | BPA-PC-ICD9 - CONDITION CODE RESTRICTION | 16 |
| 4952 | BPA-PC-ICD9 - OCCURRENCE CODE RESTRICTION | 16 |
| 4953 | BPA-RR-DRG - OTHER DTL DIAG RESTRICTION | 16 |
| 4960 | BPA-RP-NDC - BENE PLAN RESTRICTION | 16 |
| 4961 | BPA-RP-PROC - PROV COUNTY RESTRICTION | 16 |
| 4962 | BPA-PC-DRUG - GENDER RESTRICTION | 16 |
| 4963 | BPA-PC-PROC - GENDER RESTRICTION | 16 |
| 4964 | BPA-PC-REV - GENDER RESTRICTION | 16 |
| 4965 | BPA-PC-DRUG - BENEFIT PLAN RESTRICTION | 16 |
| 4966 | BPA-RR - DIAGNOSIS RESTRICTION | 16 |
| 4970 | BPA-RP-REV - BENE PLAN RESTRICTION | 16 |
| 4971 | BPA-RP-REV - CONDITION CODE RESTRICTION | 16 |
| 4972 | BPA-RP-REV - OCCURRENCE CODE RESTRICTION | 16 |
| 4973 | BPA-RR-PROC - ANY DTL DIAG RESTRICTION | 16 |
| 4975 | BPA-PC-REV - NO RULE FOR BENEFIT PLAN | 16 |
| 4976 | BPA-PC-REV - CONDITION CODE RESTRICTION | 16 |
| 4977 | BPA-PC-REV - OCCURRENCE CODE RESTRICTION | 16 |
| 4980 | BPA-RP-PROC - BENE PLAN RESTRICTION | 16 |
| 4981 | BPA-RP-PROC - CONDITION CODE RESTRICTION | 16 |
| 4982 | BPA-RP-PROC - OCCURRENCE CODE RESTRICTION | 16 |
| 4983 | BPA-RR-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 |
| 4990 | BPA-PC-PROC - BENEFIT PLAN RESTRICTION | 16 |
| 4991 | BPA-PC-PROC - CONDITION CODE RESTRICTION | 16 |
| 4992 | BPA-PC-PROC - OCCURRENCE CODE RESTRICTION | 16 |
| 4993 | BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION | 16 |
| 4999 | RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICARE PART A OR B, THE RECIPIENT IS ELIGIBLE FOR MEDICARE PART D DRUG COVERAGE AND MEDICAID WILL ONLY PAY FOR DRUGS SPECIFICALLY EXCLUDED FROM MEDICARE PART D. | 46 |
| 5000 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BILLED. | 18 |
| 5001 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5010 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5012 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5013 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5014 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 5015 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5016 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 |
| 5020 | SUSPECT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 |
| 5021 | EXACT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 |
| 5022 | DUPLICATE RX CODE FOR SAME DATE OF SERVICE. | 18 |
| 5200 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR VACCINE REPLACEMENT | 97 |
| 5201 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR VACCINE REPLACEMENT | 97 |
| 5202 | CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE | 97 |
| 5203 | CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE | 97 |
| 5204 | VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY. | 97 |
| 5205 | VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY. | 97 |
| 5206 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE | 97 |
| 5207 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE | 97 |
| 5208 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE. | 97 |
| 5209 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE. | 97 |
| 5210 | OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLED ON THE SAME DAY | B5 |
| 5211 | OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLED ON THE SAME DAY | B5 |
| 5212 | PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518567 | B5 |
| 5213 | PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518567 | B5 |
| 5214 | PROCEDURE CODE NOT ALLOWED ON THE SAME DAY | B5 |
| 5230 | SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE | 97 |
| 5231 | SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE | 97 |
| 5232 | DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAY NOT BE BILLED ON THE SAME DAY AS A PROCEDURE FOR CATHETER PLACEMENT. | B5 |
| 5233 | DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAY NOT BE BILLED ON THE SAME DAY AS A PROCEDURE FOR CATHETER PLACEMENT. | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|--|-------------------------------|
| 5234 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | B5 |
| 5235 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | B5 |
| 5236 | QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED | 119 |
| 5238 | PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS OR ON SAME DAY OF EACH OTHER. | |
| 5239 | PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS OR ON SAME DAY OF EACH OTHER. | |
| 5240 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY. | 97 |
| 5241 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY. | 97 |
| 5260 | BATTERIES MAY NOT BE PURCHASED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AID | 119 |
| 5261 | BATTERIES MAY NOT BE PURCHASED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AID | 119 |
| 5262 | PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER | B5 |
| 5270 | CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMBER AS 99241-99245 AND 99281-99285ER AS 99241-99245 AND 99281-99286ER AS 99241-99245 AND 99281-99287 | B5 |
| 5271 | CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY | B5 |
| 5280 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5281 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5282 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5283 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5284 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5300 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5301 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5302 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5303 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5304 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5305 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 5306 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5307 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5308 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5309 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5310 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5311 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5312 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5313 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 |
| 5314 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5315 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5316 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5317 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5318 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5319 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5320 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5321 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5322 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5323 | PULP THERAPY COMBINATION NOT ALLOWED | B5 |
| 5324 | WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE MUST BE BILLED. | B15 |
| 5325 | WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE MUST BE BILLED. | B15 |
| 5326 | CORE BUILDUP NOT COVERED WITH OTHER RESTORATION | B5 |
| 5327 | CORE BUILDUP NOT COVERED WITH OTHER RESTORATION | B5 |
| 5328 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER. | B5 |
| 5329 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER. | B5 |
| 5330 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE. | B5 |
| 5331 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE. | B5 |
| 5332 | THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL | 97 |
| 5333 | THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL | 97 |
| 5334 | PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR OTHER EMERGECCNY PROCEDURES ON THE SAME DAY. | 97 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 5335 | PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR OTHER EMERGENCY PROCEDURES ON THE SAME DAY. | 97 |
| 5336 | DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN. | 119 |
| 5338 | ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY. | 119 |
| 5350 | NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME. | 107 |
| 5351 | PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE. | B5 |
| 5352 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 125 |
| 5353 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 125 |
| 5354 | TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING | B5 |
| 5355 | TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING | B5 |
| 5400 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER | B5 |
| 5401 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER | B5 |
| 5402 | SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICES ON THE SAME DAY | B5 |
| 5403 | SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICES ON THE SAME DAY | B5 |
| 5404 | EPSDT VISIT HAS BEEN PAID FOR THIS RECIPIENT FOR THE SAME DATE OF SERVICE. | 18 |
| 5410 | MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE. | 119 |
| 5411 | MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE. | 119 |
| 5412 | PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE. | B5 |
| 5413 | PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE. | B5 |
| 5414 | EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY | B5 |
| 5415 | EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY | B5 |
| 5416 | VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 |
| 5417 | VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 |
| 5430 | AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC OR HOME VISIT. | B5 |
| 5431 | AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC OR HOME VISIT. | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 5432 | PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING. | B5 |
| 5433 | PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING. | B5 |
| 5434 | PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD. | 119 |
| 5436 | SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION | B5 |
| 5437 | SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION | B5 |
| 5438 | COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY. | B5 |
| 5439 | COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY. | B5 |
| 5440 | FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION | B5 |
| 5441 | FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION | B5 |
| 5451 | HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME CLAIM. | B5 |
| 5460 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 |
| 5461 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 |
| 5462 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450). | 97 |
| 5464 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | |
| 5465 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | |
| 5470 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 |
| 5471 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 |
| 5472 | CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY | B5 |
| 5473 | CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY | B5 |
| 5474 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5475 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5476 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5477 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 5478 | COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS | B5 |
| 5479 | COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS | B5 |
| 5480 | COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5481 | COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5482 | COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5483 | COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5484 | LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT. | 125 |
| 5486 | CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE | 125 |
| 5488 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5500 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | 18 |
| 5501 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | 18 |
| 5502 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5503 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5504 | POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT | B5 |
| 5505 | POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT | B5 |
| 5506 | PROVIDER MAY NOT BILL FOR NEWBORN RESUSCITATION UNLESS LIFE THREATENING | 125 |
| 5507 | PROVIDER MAY NOT BILL FOR NEWBORN RESUSCITATION UNLESS LIFE THREATENING | 125 |
| 5508 | SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID ALLOWED | B5 |
| 5509 | SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID ALLOWED | B5 |
| 5510 | PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY | 119 |
| 5511 | PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY. | B14 |
| 5512 | PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT. | B5 |
| 5513 | PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT. | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 5514 | THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED | 97 |
| 5515 | THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED | 97 |
| 5516 | ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB CARE | 97 |
| 5517 | ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB CARE | 97 |
| 5518 | LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BILLED SEPARATELY WITH A DELIVERY PROCEDURE CODE | 97 |
| 5519 | LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BILLED SEPARATELY WITH A DELIVERY PROCEDURE CODE | 97 |
| 5520 | REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE | 59 |
| 5521 | REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE | 59 |
| 5522 | ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB PROCEDURE | 97 |
| 5523 | ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB PROCEDURE | 97 |
| 5524 | POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DELIVERY | 97 |
| 5525 | POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DELIVERY | 97 |
| 5600 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 |
| 5601 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 |
| 5602 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5603 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 |
| 5604 | PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE. | 97 |
| 5605 | PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE. | 97 |
| 5606 | PAYMENT MADE FOR SIMILAR PROCEDURE | 97 |
| 5607 | PAYMENT MADE FOR SIMILAR PROCEDURE | 97 |
| 5608 | SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT. | 97 |
| 5609 | SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT. | 97 |
| 5610 | PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95120 - 95134. | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 5611 | PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT. | B5 |
| 5612 | PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95135-95170, 95135-95171,95135-95172 | B5 |
| 5613 | PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95135-95170, 95135-95171, 95135-95172 | B5 |
| 5614 | PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947 | B5 |
| 5615 | PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947 | B5 |
| 5616 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 |
| 5617 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 |
| 5618 | THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAME DAY | B5 |
| 5619 | THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAME DAY | B5 |
| 5620 | STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER. | B5 |
| 5621 | STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER. | B5 |
| 5622 | ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT | B5 |
| 5623 | ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT | B5 |
| 5624 | EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY | B14 |
| 5625 | EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY | B14 |
| 5626 | PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY | B5 |
| 5627 | PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY | B5 |
| 5628 | THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOTHER NUMBER FOR THIS PROVIDER | B13 |
| 5629 | THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOTHER NUMBER FOR THIS PROVIDER | B13 |
| 5630 | INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY. | 97 |
| 5631 | INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY. | 97 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 5632 | EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER RELATED SURGERY | 97 |
| 5633 | INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY | 97 |
| 5634 | THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME DAY | B14 |
| 5635 | THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME DAY | B14 |
| 5636 | HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY PROCEDURE CODE | 97 |
| 5637 | HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY PROCEDURE CODE | 97 |
| 5638 | HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL | 97 |
| 5639 | HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL | 97 |
| 5640 | SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE | B14 |
| 5641 | SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE | B14 |
| 5642 | ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL ABORTION COST AND ARE NOT REIMBURSABLE SEPARATELY | 97 |
| 5643 | ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL ABORTION COST AND ARE NOT REIMBURSABLE SEPARATELY | 97 |
| 5644 | HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY | B14 |
| 5645 | HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY | B14 |
| 5646 | POST-OPERATIVE PHYSICAIN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITHIN 62 DAYS OF SURGERY | 97 |
| 5647 | POST-OPERATIVE PHYSICAIN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITHIN 62 DAYS OF SURGERY | 97 |
| 5648 | PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134) | B5 |
| 5650 | ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY | B14 |
| 5652 | ONLY ONE INITIAL NICU PROCEDURE MAY BE BILLED PER HOSPITAL STAY. | 119 |
| 5656 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 |
| 5658 | A CARDIOLOGIST OR A RADIOLOGIST CANNOT BILL THIS PROCEDURE CODE ON THE SAME DAY | 18 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 5660 | ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY | B14 |
| 5661 | SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITIAL CARE. | B5 |
| 5710 | SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 |
| 5711 | SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 |
| 5712 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 |
| 5713 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5714 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B7 |
| 5715 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B7 |
| 5716 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 |
| 5717 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 |
| 5718 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 |
| 5719 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 |
| 5720 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5721 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5722 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 |
| 5723 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 |
| 5724 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5725 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5726 | THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT | B5 |
| 5727 | THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT | B5 |
| 5728 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5729 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 |
| 5730 | THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES | 96 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 5731 | THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES | 96 |
| 5732 | THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY | B5 |
| 5733 | THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY | B5 |
| 5734 | THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY | B5 |
| 5735 | THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY | B5 |
| 5736 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 |
| 5738 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 |
| 5740 | INDIVIDUAL THERAPY AND GROUP THERAPY MAY NOT BE BILLED ON THE SAME DAY. | B14 |
| 5750 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY | B5 |
| 5751 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY | B5 |
| 5752 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY | B5 |
| 5753 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY | B5 |
| 5754 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT | 18 |
| 5755 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT | 18 |
| 5760 | ESWL PRICING | 42 |
| 5770 | INDEPENDENT RURAL HEALTH CLINICS CANNOT BE PAID FOR MORE THAN ONE SERVICE PER DAY. | 119 |
| 5790 | PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA | 119 |
| 5791 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 |
| 5792 | BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS. | 119 |
| 5800 | RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR THE SAME DOS. | 18 |
| 5801 | RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR THE SAME DOS. | 18 |
| 5802 | PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME DAY | B5 |
| 5803 | PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME DAY | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 5804 | ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE. | 18 |
| 5811 | HEARING AND VISION SCREENING REQUIRE EP MODIFIER. | B18 |
| 5812 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON OR POST-CATARACT FOLLOW-UP CARE CANNOT BE PAID UNTIL THE SURGEON HAS BEEN PAID. CONTACT THE SURGEON | B5 |
| 5813 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON OR POST-CATARACT FOLLOW-UP CARE CANNOT BE PAID UNTIL THE SURGEON HAS BEEN PAID. CONTACT THE SURGEON | B5 |
| 5814 | PROCEDURE NOT COVERED WITH SPECIFIC CODES. | 97 |
| 5815 | VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LIMITED TO ONCE PER YEAR | 119 |
| 5816 | HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES. | B5 |
| 5817 | REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER. | B5 |
| 5818 | THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT. | B5 |
| 5819 | OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE. | B5 |
| 5830 | PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOOTH NUMBER. | B5 |
| 5831 | MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE CODE IS NOT COVERED. | B5 |
| 5832 | MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE CODE IS NOT COVERED. | B5 |
| 6001 | THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MONTH. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6010 | INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6020 | HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS. | 119 |
| 6021 | MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6022 | MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS. | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6023 | HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6024 | THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6025 | EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS. | 119 |
| 6026 | BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS. | 119 |
| 6030 | NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT | 119 |
| 6041 | | |
| 6042 | | |
| 6043 | | |
| 6044 | EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR. | 119 |
| 6045 | DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME. | 119 |
| 6046 | PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS | 119 |
| 6047 | PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS | 119 |
| 6048 | FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS | 119 |
| 6049 | PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH. | 119 |
| 6050 | PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS | 119 |
| 6051 | FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS | 119 |
| 6052 | CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION | 15 |
| 6053 | COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER. | 119 |
| 6100 | PROCEDURE IS LIMITED TO SIXTY (60) PER CALENDAR MONTH. | 119 |
| 6101 | PROCEDURE IS LIMITED TO FIFTEEN (15) PER CALENDAR MONTH. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6102 | PROCEDURE IS LIMITED TO ONE (1) EVERY FIVE YEARS | 119 |
| 6103 | PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 6104 | PROCEDURE CODE IS LIMITED TO ONE-HUNDRED (100) PER MONTH. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6105 | PROCEDURE IS LIMITED TO 60 (SIXTY) TIMES PER CALENDAR MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6106 | PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6107 | PROCEDURE CODE IS LIMITED TO 40 (FORTY) PER CALENDAR MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6108 | PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS | 119 |
| 6109 | PROCEDURE CODE IS LIMITED TO 100 PER MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6110 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6111 | THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6112 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6113 | PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6114 | PROCEDURE IS LIMITED TO TWO PER YEAR. | 119 |
| 6115 | MEDICAL SUPPLIES LIMIT IS \$1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6116 | PROCEDURE IS LIMITED TO ONE (1) EVERY FOUR CALENDAR YEARS. | 119 |
| 6117 | THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6118 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6119 | PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6120 | THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH. | 119 |
| 6121 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6122 | LEG BAGS ARE LIMITED TO TWO PER MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6123 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6124 | PROCEDURE IS LIMITED TO ONE (1) EVERY THREE YEARS. | 119 |
| 6125 | CATHETERS, CATHETER TRAYS, AND DRAINAGE BAGS ARE LIMITED TO TWO PER MONTH. | 119 |
| 6126 | PROCEDURE IS LIMITED TO ONE HUNDRED TWENTY (120) PER CALENDAR MONTH. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6150 | VISION AND HEARING SCREENING ONE PER YEAR | 119 |
| 6151 | INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME | 119 |
| 6152 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6153 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6154 | MAXIMUM UNIT LIMIT HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6155 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED. | 119 |
| 6180 | THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6181 | THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED | 119 |
| 6182 | THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED | 119 |
| 6183 | THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED. | 119 |
| 6184 | THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED | 119 |
| 6200 | THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR. | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6201 | FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6202 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6203 | THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD. | 119 |
| 6204 | INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME | 119 |
| 6205 | THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR | 119 |
| 6206 | PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977 CANNOT BE BILLED WITHIN 60 MONTHS OF INSERTION | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6207 | THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE ONLY. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |
| 6208 | PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS. | 119 |
| 6209 | PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |
| 6230 | MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE SAME DATE OF SERVICE. | B5 |
| 6231 | MORE THAN ONE DENTAL ENCOUNTER (D9430)CANNOT BE PAID ON THE SAME DATE OF SERVICE. | B14 |
| 6240 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6241 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6242 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6243 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6244 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 6245 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6246 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6247 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6248 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6249 | HBO LIMIT HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6260 | NUMBER OF HOME HEALTH VISITS EXCEED LIMIT | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6280 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR | 119 |
| 6281 | OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6282 | INPATIENT DAYS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6283 | REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER. | B5 |
| 6290 | MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY | B5 |
| 6291 | SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY | 119 |
| 6300 | THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS. | 119 |
| 6301 | MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS | 119 |
| 6302 | MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS. | B5 |
| 6303 | MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS. | B5 |
| 6310 | THE QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED FOR THE DRUG CODE PRESCRIBED. | 119 |
| 6311 | QTY DISPENSED EXCEEDS MAX QTY BASED ON PA | 62 |
| 6312 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 |
| 6313 | MONTHLY SCRIPT LIMIT EXCEEDED - BRANDED DRUG | |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| 6314 | MONTHLY SCRIPT LIMIT EXCEEDED | |
| 6400 | SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY | 119 |
| 6401 | OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUIRE PRIOR AUTHORIZATION. | 119 |
| 6402 | SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR | 119 |
| 6403 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR. | 119 |
| 6404 | PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER | 119 |
| 6405 | PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6406 | NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE | 119 |
| 6407 | THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIPIENT IN A THREE YEAR PERIOD. | 119 |
| 6408 | PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT | B14 |
| 6409 | REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16 | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6410 | PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6411 | INITIAL CRITICAL CARE LIMITED TO ONE PER DAY | 119 |
| 6412 | ER AND CRITICAL CARE CODE ONE PER CLAIM. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |
| 6413 | REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16 | |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | |
| 6510 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6511 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6512 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|--|------------------------|
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6513 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6514 | THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |
| 6515 | THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR | 119 |
| 6516 | THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6517 | THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6518 | PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6519 | PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6520 | PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6521 | THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6522 | THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6523 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6524 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6525 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6526 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6527 | BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|---|-------------------------------|
| | YEAR. | |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6528 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6529 | PROCEDURE IS LIMITED TO 260 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6530 | PROCEDURE IS LIMITED TO 8 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6531 | PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6532 | PROCEDURE IS LIMITED TO 1040 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6533 | PROCEDURE IS LIMITED TO 1040 UNITS A YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6534 | PROCEDURE IS LIMITED TO 2016 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6535 | PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6536 | PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6537 | PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6538 | YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6539 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6540 | PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF SERVICE 21" (INPATIENT) " | 119 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6541 | DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR | 119 |
| 6542 | PROCEDURE IS LIMITED TO 4160 UNITS A YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6610 | DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER RECIPIENT. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6611 | PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6612 | PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH. | 119 |
| 6613 | PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6630 | THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH. | 119 |
| 6640 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6641 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6642 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6643 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |
| 6644 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6645 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | B5 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | B5 |

| EOB Code | EOB Description | Adjustment Reason Code |
|-----------------|--|-------------------------------|
| 6646 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 18 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 18 |
| 6647 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6650 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THIS CONTRACT YEAR | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6651 | UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED | 119 |
| 6652 | UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED | 119 |
| 6653 | PROCEDURE LIMITED TO 1080 HOURS,PER WAIVER YEAR OCTOBER 1 - SEPTEMBER 30. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6670 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 |
| 6671 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS RECIPIENT. | 18 |
| 6672 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT | 18 |
| 6673 | PROCEDURE IS LIMITED TO ONE (1) EVERY TWO YEARS. | 119 |
| 6674 | CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL. | 133 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 133 |
| 6677 | PROCEDURE CODE CANNOT BE BILLED MORE THAN SIX(6) TIMES WITH THE SAME MODIFIER. | 18 |
| 6690 | REVENUE CODE 183 IS LIMITED TO 6 DAYS EACH CALENDAR QUARTER. | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 6691 | REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDAR MONTH | 119 |
| 6999 | UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT | 119 |
| 7000 | CLAIM FAILED A PRODUR ALERT | 133 |
| 7001 | INFORMATIONAL PRODUR ALERT | 175 |
| 7002 | CLAIM DENIED FOR PRODUR REASONS | 6 |
| 7003 | PRODUR ALERT REQUIRES PA FOR OVERRIDE | 6 |
| 7004 | NON-OVERRIDEABLE PRODUR ALERT | 6 |
| 7503 | CONFLICT CODE ON RESPONSE CLAIM DOES NOT MATCH | 6 |

| EOB Code | EOB Description | Adjustment Reason Code |
|----------|---|------------------------|
| 8188 | VOID TRANSACTIONS-MASS ADJUSTMENT | |
| 8200 | CORRECTION TO A PRIOR CLAIM | 63 |
| 8201 | DUPLICATE PAYMENT | 63 |
| 8202 | CLAIM BILLED IN ERROR | 63 |
| 8203 | BILLED UNDER WRONG RECIPIENT | 63 |
| 8204 | PRIMARY INSURANCE PAYMENT RECEIVED | 63 |
| 8205 | PROVIDER TO REBILL | 63 |
| 8206 | DUE TO MEDICARE PRIMARY | 63 |
| 8207 | RECOUPMENT OTHER | 63 |
| 8217 | DUE TO MISCELLANEOUS OR UNSPECIFIED REASON | 45 |
| 8220 | FULL REFUND | 23 |
| 8221 | PARTIAL REFUND | 23 |
| 8241 | ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY | 45 |
| 8242 | ADJUSTMENT GENERATED DUE TO RATE CHANGE | 45 |
| 9999 | PROCESSED PER MEDICAID POLICY | 92 |

This page intentionally left blank.