J

J. Provider Remittance Advice (RA) Codes

Added: and Remark Codes

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

J.1 Explanation of Benefit (EOB) Codes

Replaced table

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
201	INVALID PAY-TO PROVIDER NUMBER	125	N280
202	BILLING PROVIDER ID IN INVALID FORMAT	125	N257
203	RECIPIENT I.D. NUMBER MISSING	31	N382
206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT	16	N31
210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	125	
211	INVALID REFILL INDICATOR VALUE	16	
212	MISSING PRESCRIPTION NUMBER	16	N388
215	DATE DISPENSED IS MISSING	16	N304
216	DATE DISPENSED IS INVALID	16	N304
217	MISSING DRUG CODE	16	M119
218	INVALID DRUG CODE	16	M119
219	QUANTITY DISPENSED IS MISSING	16	N378
220	QUANTITY DISPENSED IS INVALID	16	N378
223	MISSING DIAGNOSIS INDICATOR	16	M76
224	DIAGNOSIS TREATMENT INDICATOR INVALID	16	M76
225	REFERRING PROVIDER - INVALID FORMAT	16	N286
226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER	16	N286
228	CLAIMANT SIGNATURE MISSING	16	MA75
229	SOURCE OF ADMISSION MISSING	16	MA42
230	MISSING ATTENDING SURGEON PRESCRIBER NUMBER	16	N262
231	CLAIM WAS FILED WITHOUT SERVICING PROVIDER	16	N290
233	UNITS OF SERVICE MISSING	16	M53
234	PROCEDURE CODE MISSING	16	M51
235	PROCEDURE CODE NOT IN VALID FORMAT	16	M51
238	RECIPIENT NAME IS MISSING	16	MA36
239	DETAIL TO DATE OF SERVICE IS MISSING	16	M59
240	THE DETAIL "TO" DATE IS INVALID	16	M59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
243	MISSING MEDICARE PAID DATE	226	N307
245	MISSING OCCURRENCE CODE	129	
247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	16	
248	PLACE OF SERVICE IS MISSING OR BLANK	16	M77
249	PLACE OF SERVICE IS INVALID	16	M77
250	CLAIM HAS NO DETAILS	16	M77
258	MISSING DIAGNOSIS CODE	16	M76
259	DATE BILLED IS INVALID	16	MA31
260	UNITS OF SERVICE NOT IN VALID FORMAT	16	M53
261	MISSING TOOTH NUMBER	16	N37
262	INVALID TOOTH NUMBER	16	N37
263	INVALID TOOTH SURFACE	16	N75
264	DETAIL FROM DATE OF SERVICE IS MISSING	16	M52
265	DETAIL FROM DATE OF SERVICE IS INVALID	16	M52
266	MISSING TOOTH SURFACE	16	N75
268	BILLED AMOUNT INVALID	16	M79
269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT	16	M79
270	MISSING TOTAL CLAIM CHARGE	16	M54
271	INVALID TOTAL CLAIM CHARGE	16	M54
273	TYPE OF BILL MISSING	16	MA30
274	TYPE OF BILL CODE INVALID	16	MA30
275	ADMIT DATE MISSING	16	MA40
276	ADMIT DATE INVALID	16	MA40
277	INVALID ADMISSION HOUR	16	N46
278	ADMIT TYPE MISSING	16	MA41
279	INVALID TYPE OF ADMISSION	16	MA41
280	PATIENT STATUS IS MISSING	16	MA43
281	PATIENT STATUS IS INVALID	16	MA43
282	MISSING COVERED DAYS	16	MA32
283	COVERED DAYS INVALID	16	MA32
284	PRIMARY CONDITION CODE INVALID	16	M44
285	SECOND CONDITON CODE INVALID	16	M44
286	THIRD CONDITION CODE INVALID	16	M44
287	FOURTH CONDITION CODE INVALID	16	M44
288	FIFTH CONDITION CODE INVALID	16	M44
289	SIXTH CONDITION CODE INVALID	16	M44
290	SEVENTH CONDITION CODE INVALID	16	M44
291	PRIMARY OCCURRENCE CODE INVALID	129	M44
292	SECOND OCCURRENCE CODE INVALID	129	M45
293	THIRD OCCURRENCE CODE INVALID	16	M45
294	FOURTH OCCURRENCE CODE INVALID	129	M45
295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	16	N299

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
296	DATE FOR PRIMARY OCCURRENCE CODE INVALID	16	N299
297	DATE FOR SECOND OCCURRENCE CODE MISSING	16	N299
298	DATE FOR SECOND OCCURRENCE CODE INVALID	16	N299
299	DATE FOR THIRD OCCURRENCE CODE MISSING	16	N299
300	DATE FOR THIRD OCCURRENCE CODE INVALID	16	N299
301	DATE FOR FOURTH OCCURRENCE CODE MISSING	16	N299
302	DATE FOR FOURTH OCCURRENCE CODE INVALID	16	N299
339	REVENUE CODE IS MISSING	16	M50
340	REVENUE CODE IS INVALID	16	M50
350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT	16	M50
363	PRINCIPAL ICD9 PROCEDURE CODE IS INVALID	16	
364	PRINCIPAL ICD9 PROCEDURE DATE MISSING	16	N303
365	PRINCIPAL ICD9 PROCEDURE DATE INVALID	16	N303
366	FIRST OTHER PROCEDURE CODE INVALID	16	
367	FIRST OTHER ICD9 PROCEDURE DATE MISSING	16	N302
368	FIRST OTHER ICD9 PROCEDURE DATE INVALID	16	N302
369	SECOND OTHER PROCEDURE CODE INVALID	16	M67
370	SECOND OTHER ICD9 PROCEDURE DATE MISSING	16	N302
371	SECOND OTHER ICD9 PROCEDURE DATE INVALID	16	N302
372	THIRD OTHER PROCEDURE CODE INVALID	16	
373	THIRD OTHER ICD9 PROCEDURE DATE MISSING	16	N302
374	THIRD OTHER ICD9 PROCEDURE DATE INVALID	16	N302
375	FOURTH OTHER PROCEDURE CODE INVALID	16	
376	FOURTH OTHER ICD9 PROCEDURE DATE MISSING	16	N302
377	FOURTH OTHER ICD9 PROCEDURE DATE INVALID	16	N302
378	FIFTH OTHER PROCEDURE CODE INVALID	16	
379	FIFTH OTHER ICD9 PROCEDURE DATE MISSING	16	N302
380	FIFTH OTHER ICD9 PROCEDURE DATE INVALID	16	N302
381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING	16	N253
395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	16	M52
396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	16	M52

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	16	M52
398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	16	M52
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	16	M53
405	FIFTH OCCURRENCE CODE INVALID	129	M53
406	SIXTH OCCURRENCE CODE INVALID	129	M45
407	SEVENTH OCCURRENCE CODE INVALID	129	M45
408	EIGHTH OCCURRENCE CODE INVALID	129	M45
409	FIRST OCCURRENCE SPAN CODE INVALID	129	M45
410	SECOND OCCURRENCE SPAN CODE INVALID	129	M45
411	DATE FOR FIFTH OCCURRENCE CODE MISSING	16	N299
412	DATE FOR FIFTH OCCURRENCE CODE INVALID	16	N299
413	DATE FOR SIXTH OCCURRENCE CODE MISSING	16	N299
414	DATE FOR SIXTH OCCURRENCE CODE INVALID	16	N299
415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	16	N299
416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	16	N299
417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	16	N299
418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	16	N299
419	FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING	16	M45
420	FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID	92	M46
421	TO DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING	92	M100
422	TO DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID	92	M100
423	FROM DAT OF SERV FOR 2ND OCCUR SPAN CODE MISSING	92	M100
424	FROM DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID	92	M100
425	TO DTE OF SERV FOR 2ND OCCUR SPAN CODE MISSING	92	M100
426	TO DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID	92	M100
433	MEDICARE DEDUCTIBLE AMOUNT INVALID	1	M100
434	MEDICARE COINSURANCE AMOUNT INVALID	2	
435	MEDICARE BLOOD DEDUCTIBLE AMOUNT INVALID	92	
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	125	N219
450	INVALID QUADRANT	16	N346

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
451	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE	2	
455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	125	N183
456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	16	M51
457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	16	M51
460	THE ATTACHMENT TYPE IS NOT VALID.	16	N228
461	VALUE CODE IS INVALID	16	M49
462	VALUE CODE AMOUNT IS MISSING	16	M49
463	VALUE CODE AMOUNT IS INVALID	16	M49
464	OCCURRENCE CODE 9-24 INVALID	129	
465	DATE FOR OCCURRENCE CODE 9-24 MISSING	16	N299
466	DATE FOR OCCURRENCE CODE 9-24 INVALID	16	N299
467	OCCURRENCE SPAN CODE 9-24 INVALID	16	M46
468	FROM DATE OF SERVICE FOR SPAN CODE 3-24 MISSING	16	N300
469	FROM DATE OF SERVICE FOR SPAN CODE 3-24 INVALID	16	N300
470	TO DATE OF SERVICE FOR SPAN CODE 3-24 MISSING	16	N300
471	CONDITION CODE 8-24 INVALID	16	M44
472	TO DATE OF SERVICE FOR SPAN CODE 3-24 INVALID	92	M44
473	ICD9 PROCEDURE 7-24 INVALID	16	M100
474	ICD9 PROCEDURE 7-24 OR DATE MISSING	16	N301
475	ICD9 PROCEDURE 7-24 DATE INVALID	16	N301
477	DETAIL FIRST OTHER PHYSICIAN ID INVALID	16	N262
480	THE ATTACHMENT TYPE IS NOT VALID.	16	N228
500	DATE PRESCRIBED AFTER BILLING DATE	125	N57
502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	16	N304
503	DATE DISPENSED AFTER BILLING DATE	110	N304
506	DATE DISPENSED AFTER ICN DATE	45	
507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	16	MA31
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	16	M54
511	2ND OCCURRENCE SPAN FROM DATE IS AFTER THE TO DATE	16	M46
512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	M46
513	NAME ON CLAIM MUST MATCH NAME ON FILE	140	MA36
514	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV	110	M59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE	110	MA40
526	DETAIL DATES NOT WITHIN HEADER DATES	16	MA31
527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	16	M52
536	BILLED DATE IS PRIOR TO DATES OF SERVICE	16	
537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE	125	MA31
545	PHARMACY CLAIM FILED BEYOND 365-DAY FILING	100	
554	HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE	16	MA31
555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	M100
556	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	
565	HEADER PAID AMOUNT IS GREATER THAN BILLED AMOUNT	92	
568	DISCHARGE DATE IS LESS THAN ADMIT DATE	16	
569	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV	16	N305
570	TOTAL DAYS LESS THAN COVERED DAYS	16	MA32
571	SURGICAL PROCEDURE MISSING	16	M51
573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN	16	MA32
574	SERVICE DATES ARE NOT IN SAME MONTH	16	N74
575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	16	N341
576	CLAIM HAS THIRD-PARTY PAYMENT	23	MA92
581	SPAN THRU DATE LESS THAN SPAN FROM DATE	16	
589	ADJUSTMENT HAS AUTO DENIAL	45	M85
595	MANUALLY SUSPEND FOR REVIEW	45	M85
596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	129	N61
599	ATTACHMENT CONTROL NUMBER MISSING	16	N3
602	UNITS NOT EQUAL TO TEETH BILLED	16	M53
603	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.	16	N3
605	FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24	16	
606	INVALID OTHER PAYER DATE	125	N307
607	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.	16	N3
609	PART A CROSSOVER SPANS 20020501	45	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
643	INVALID OTHER COVERAGE CODE	16	N245
652	MISSING OR INVALID OTHER PAYER COVERAGE TYPE	16	N245
675	ADJ - RECIPIENT ID NOT SUBMITTED	16	N382
676	ADJ - PROVIDER ID NOT SUBMITTED	16	N77
677	ADJ - ORIGINAL ICN NOT FOUND	107	M47
678	ADJ - ORIGINAL ICN NOT SUBMITTED	107	M47
679	ADJ - REQUEST RECIPIENT ID NOT FOUND	16	N382
680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL	16	N152
681	ADJ - ORIGINAL ICN NOT FOUND	107	M47
682	ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED	16	
683	ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS	16	
684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL	16	N152
685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS	16	N142
686	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE	16	N152
687	CANNOT ADJUST THIS CLAIM DUE TO PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT	16	M56
688	CANNOT ADJUST THIS CLAIM DUE TO PHP TERMINATION. VOID THIS CLAIM AND RESUBMIT	16	
800	DETAIL RATE NOT NUMERIC	125	M79
801	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT	125	M79
803	DATED EXCEED SOBRA/QMB ELIGIBILITY	141	N61
805	NONCOVERED CHARGE IS NOT NUMERIC	96	M79
806	MEDICARE PAID AMOUNT MISSING OR INVALID	125	MA64
807	INVALID TPL ADJUDICATION DATE	16	N307
808	TPL ADJUDUCATION DATE CANNOT BE A FUTURE DATE	16	N307
809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS	16	MA35
810	INVALID DEDUCTIBLE AMT - SKILLED NURSING FACILITY	1	
811	HEADER FROM DATE OF SERVICE > ICN DATE	125	M52
812	ADMIT DATE IS GREATER THAN ICN DATE	125	MA40
813	MEDICARE PAID DATE > ICN DATE	16	N307
814	DETAIL TO DATE OF SERVICE > ICN DATE	125	M59
815	SURGICAL ICD9 REQUIRES OPERATING PHYSICIAN	125	N262
816	COINSURANCE DAYS NOT NUMERIC	2	MA34
817	INVALID COINSURANCE DAYS	2	MA34

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
818	LIFETIME RESERVE DAYS NOT NUMERIC	125	MA35
819	LIFETIME RESERVE DAYS > MAX ALLOWED	125	MA35
820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR	125	N61
821	NON-COVERED DAYS MISSING OR NOT NUMERIC	78	MA33
822	SURGICAL REVENUE CODE REQUIRES ICD9 SURGERY CODE	125	M67
823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID	125	N382
824	UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION	B5	
825	MEDICARE ALLOWED AMOUNT MISSING OR INVALID	125	N219
826	TYPE OF BILL INVALID FOR CLAIM TYPE	16	MA30
827	NON COVERED AMOUNT IS GREATER THAN COVERED AMOUNT	125	
830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW	125	N219
831	MEDICARE HDR PAID AMNT NOT EQUAL SUM OF DTL PAID	125	
832	OTHER PAYER AMOUNT PAID QUALIFIER INVALID	16	
833	CO-INSURANCE AMOUNT DOES NOT BALANCE	2	
835	MEDICARE DATA NOT FOUND - FORMAT ERROR	16	
836	MEDICARE PAID, DEDUCTIBLE AMOUNTS INVALID - BOTH CANNOT BE ZERO **OR** MEDICAR	16	M49
900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	B7	MA112
901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE	B7	MA112
902	PROCEDURE CODE GROUP NOT FOUND	16	N55
903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T	16	M77
904	GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE	16	
905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL	16	N188
906	GROUP NUMBER NOT FOUND IN ICD-9 GROUP TABLE	16	M51
907	GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE	B7	
908	GROUP NUMBER NOT FOUND IN VALUE GROUP TABLE	B7	
909	GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE	16	M76

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
910	BENEFIT PLAN GROUP NOT FOUND	16	
911	INTERNAL PROCESSING ERROR - CONTACT EDS	16	
912	INTERNAL ERROR-DOLLAR DISTRIBUTION	16	
913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE	16	M50
914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE	16	MA30
915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE	B7	MA112
916	GROUP NOT FOUND IN PROVIDER GROUP TABLE	B7	MA112
917	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE	16	M51
918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR	16	N75
919	GROUP NUMBER NOT FOUND IN AID CODE TABLE	16	N216
920	DRUG THERAPEUTIC CLASS GROUP NOT FOUND	16	
921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE	B7	MA112
922	TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE	1	
923	RULE OVERLAP IDENTIFIED	16	
1000	NO PAY-TO PROVIDER RECORD	16	N279
1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE	B7	N257
1002	PERFORMING PROV NOT ELIGIBLE FOR DOS	B7	N277
1003	PROVIDER INELIGIBLE ON DATE OF SERVICE	B7	N95
1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE	16	N290
1010	PERFORMING PROVIDER NOT IN BILLING GROUP	16	N55
1018	CLINIC RATE NOT ON FILE FOR HOSPITAL	16	N65
1019	MULTIPLE RATES FOR LEVEL OF CARE - RATE CHANGE OVERLAPS SERVICE DATES; SPLIT BI	16	
1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV	38	N31
1027	REFERRING PROVIDER NOT FOUND	100	N31
1032	PROVIDER TYPE - CLAIM INPUT CONFLICT	125	N34
1049	BILLING PROVIDER ENROLLMENT STATUS INVALID	B7	
1050	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER	38	N286
1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)	16	N277

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
1052	OTHER-2 (REFERRING) PROVIDER ID NOT ON FILE - DTL	16	N286
1053	OTHER-1 (OPERATING) PROVIDER ID NOT ON FILE - DTL	16	N262
1055	DTL REFERRING PROV NOT ON FILE	16	N286
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM	16	
1065	PROVIDER NAME MISMATCH	125	N279
1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER	125	N55
1804	VERFIY PERFORMING PROVIDER NOT GROUP PROVIDER	125	N55
1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS	125	N95
1806	EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS UNDER	6	
1807	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE	16	N34
1812	RECIPIENT / ADMIT AGE GREATER THAN 21	6	
1814	BILLING PROVIDER NOT VALID FOR DATES OF SERVICE	B7	
1815	PERF PROV ENROLL STATUS NOT VALID FOR DOS	16	N290
1816	MATERNITY CARE MUST BE PERFORMED BY DISTRICT PROV	38	
1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS	8	N95
1818	WAIVER PROVIDER MISMATCH	38	
1819	INVALID POS FOR FQHC PROVIDER	5	M77
1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL	38	N286
1821	MEDICAL LOCKIN - RECIPIENT LOCKED IN TO OTHER PROVIDER	38	
1822	MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES	38	
1823	WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES	38	
1824	LTC ASSIGNMENT DATES OVERLAP CLAIM DATES	38	
1825	COBA DENIAL - DO NOT CROSSOVER	16	N34
1826	SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE	16	N95
1900	TAXONOMY IS INVALID BILLING PROVIDER	16	N255
1901	TAXONOMY IS INVALID PREFORMING PROVIDER	16	N288
1902	TAXONOMY IS INVALID REFERRING PROVIDER	45	
1903	TAXONOMY IS INVALID: FACILITY PROVIDER	45	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
1905	TAXONOMY IS INVALID: OTHER PROVIDER 2	45	
1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	N255
1907	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	N288
1908	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER	45	
1909	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER	45	
1911	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2	45	
1912	TAXONOMY IS MISSING: BILLING PROVIDER	16	N255
1913	TAXONOMY IS MISSING: PERFORMING PROVIDER	16	N288
1914	TAXONOMY IS MISSING: REFERRING PROVIDER	45	
1915	TAXONOMY IS MISSING: FACILITY PROVIDER	45	
1917	TAXONOMY IS MISSING: OTHER PROVIDER 2	45	
1918	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2	45	
1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	N288
1920	TAXONOMY IS INVALID: DTL REFERRING PROVIDER	45	
1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER	16	N288
1922	TAXONOMY IS MISSING: DTL REFERRING PROVIDER	45	
1923	TAXONOMY IS MISSING: DTL OTHER PROVIDER 2	45	
1924	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2	45	
1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	N288
1926	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER	45	
1927	BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N	206	N257
1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV	206	N290
1929	NPI REQUIRED HEALTHCARE=Y REFERRING PROV	45	
1930	NPI REQUIRED HEALTHCARE=Y FACILITY PROV	45	
1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV	206	N290
1932	NPI REQUIRED: OTHER PROVIDER 2 (HEALTHCARE)	45	
1933	NPI REQUIRED: DTL OTHER PROVIDER 2 (HEALTHCARE)	45	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	206	N290
1935	DTL NPI REQUIRED HEALTHCARE=Y REFERRING PROV	45	
1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)	16	N253
1961	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)	16	N262
1962	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)	16	N286
1974	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	N288
1975	TAXONOMY IS INVALID: DTL REFERRING PROVIDER	16	N284
1976	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2	16	N94
1977	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2	16	N94
1978	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	N288
1979	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER	16	N284
1980	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	N255
1981	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	N288
1982	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER	16	N284
1983	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER	16	N94
1984	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2	16	N94
1985	TAXONOMY IS INVALID: BILLING PROVIDER	16	N255
1986	TAXONOMY IS INVALID: PERFORMING PROVIDER	16	N288
1987	TAXONOMY IS INVALID: REFERRING PROVIDER	16	N284
1988	TAXONOMY IS INVALID: FACILITY PROVIDER	16	N94
1989	TAXONOMY IS INVALID: OTHER PROVIDER 2	16	N94
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.	B7	
2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	N30
2011	PHARMCY MEDICAL/NON-MEDICAL SUPPL. AND ROUTINE DME	92	
2017	RECIPIENT SERVICES COVERED BY HMO PLAN	24	M100

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	96	N30
2054	UNABLE TO DETERMINE FUND CODE - DETAIL	16	
2055	UNABLE TO DETERMINE AID CAT OR COUNTY	16	
2057	RECIPIENT PARTIALLY ELIGIBILE - HEADER	141	N61
2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES	141	N61
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	22	N4
2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT)	22	N4
2506	INSURANCE DENIAL REQUIRED	129	N4
2507	THIS PATIENT HAS TWO COVERAGE TYPES	22	N4
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	22	N4
2509	FILE CLAIM WITH MEDICARE	109	N104
2510	HMO CO-PAY/RECIPIENT HAS TPL	22	N4
2511	HMO CO-PAY/RECIPIENT HAS MEDICARE	22	
2512	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE	22	
2514	RECIPIENT COVERED BY MEDICARE(A AND B), NO MED D)	109	
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	
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	N288
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	N288
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	N288

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
2804	DETAILS COVERED BY MORE THAN ONE PLAN CODE	141	N61
2805	DOS PRIOR TO DOB	14	
2806	PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX	16	
2807	COBA-NO MEDICAID ID FOR MEDICARE ID	31	N382
2808	COBA - MEDICARE ID NOT ON FILE	31	N382
3018	STOP LOSS THRESHOLD REACHED - ENCOUNTER CLAIMS	45	M100
3019	PA CUTBACK PERFORMED	45	N123
3021	DRG REQUIRES PA	92	
3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH	16	M100
3101	ONLINE PA DENIED BY HID, NDC REQUIRES PA	16	
3102	ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM	16	
3103	ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS	16	
3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES	15	M62
3105	DAW 1 - BRAND WITH GENERIC EQUIVALENT REQUIRES OVERRIDE	16	
3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH	B5	M76
3301	BILL EMERGENCY PROCEDURE/REVENUE TOGETHER	199	
3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID	B5	M50
3304	NON-COVERED SVC FOR RECIPIENT < 6 MONTHS OLD	6	
3306	HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT	125	
3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT	B5	N59
3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION	5	MA30
3310	DISPENSING FEE NOT LOCATED	16	
3311	REFILL NUMBER EXCEEDS MAXIMUM ALLOWED	16	
3312	DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY	16	
3313	NDC DRUG, PRODUCT IS NOT PREFERRED	16	M62
3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP	16	M97
3315	NURSERY DAYS EXCEED LIMIT	119	N362
3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID	16	M119

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
3317	CLAIM QUANTITY EXCEEDS NDC MAX UNITS	125	
3318	NDC NOT APPROPRIATE FOR RECIPIENT AGE.	6	
3319	NDC IS INAPPROPRIATE FOR RECIPIENT SEX	7	
3320	SERVICE INCLUDED IN FACILITY FEE	16	
3599	MANUAL PRICING REQUIRED	101	
3800	SERVICE COVERAGE HAS NOT BEEN DETERMINED	133	
3997	BPA-RR-DRG - ANY HDR DIAGNOSIS RESTRICTION	16	
3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM	45	
4001	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION	12	M76
4002	BPA-RP-NDC - NO COVERAGE	96	M119
4004	NDC IS NOT ON FILE	96	M119
4005	SUBMITTED TO ALLOWED EXCEEDS PERCENT	125	M54
4006	ALLOWED TO SUBMITTED EXCEEDS PERCENT	125	M54
4009	ALLOWED TO SUBMITTED EXCEEDS PERCENT	125	M54
4010	MODIFIER REQUIRES MEDICAL REVIEW	133	
4011	INVALID MODIFIER COMBINATION	4	
4013	PROCEDURE CODE IS NO LONGER VALID	96	M51
4014	NO PRICING SEGMENT IS ON FILE.	133	N65
4015	PASARR ASSESSMENT PROCEDURE FOR REVIEW	92	
4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	12	M76
4017	BPA-RP-DRG - BILL PROV PRIMARY PT/PS RESTRICTION	16	
4018	BPA-RP-DRG - PERF PROV PRIMARY PT/PS RESTRICTION	16	
4021	BPA-RP-PROC - NO COVERAGE	96	M51
4023	BPA-RP-NDC - GENDER RESTRICTION	16	
4025	BPA-RP-NDC - AGE RESTRICTION	16	
4026	BPA-RP-NDC - MAX UNIT RESTRICTION	16	
4028	BPA-RP-DIAG - GENDER RESTRICTION	10	
4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION	16	M77
4030	BPA-RP-DIAG - AGE RESTRICTION	9	
4031	BPA-PC-DIAG - GENDER RESTRICTION	10	
4032	PROCEDURE CODE IS MISSING/NOT ON FILE	96	M51
4034	BPA-RP-PROC - AGE RESTRICTION	6	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4035	BPA-RP-PROC - GENDER RESTRICTION	7	
4036	BPA-RP-PROC - PLACE OF SERVICE RESTRICTION	5	
4044	BPA-RR-DIAG - NO RULE FOR ASSOC AGE	9	
4045	BPA-RR - NO RULE FOR BENEFIT PLAN	16	
4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	96	N56
4053	PRINCIPAL PROCEDURE CODE NOT ON FILE	16	
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	16	N65
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	16	N65
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	16	N65
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	16	N65
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	16	N65
4059	REVENUE CODE NOT ON FILE	16	M50
4061	BPA-RR - NO RULE FOR CLAIM TYPE	16	N34
4062	BPA-RR - NO RULE FOR COND CODE	16	M44
4064	BPA-RP-ICD9 - GENDER RESTRICTION	16	MA39
4068	BPA-RR - NO RULE CURR BILL PROV CONTRACT	B7	
4070	BPA-RR-PROC - MODIFIER RESTRICTION	4	
4072	BPA-RR-DRG - NO RULE FOR ADMIT OR HDR DIAGNOSIS	16	
4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION	16	MA63
4075	BPA-RP-ICD9 - FAMILY PLANNING IND RESTRICTION	16	M51
4076	BPA-RP-NDC - FAMILY PLANNING IND RESTRICTION	16	
4077	NON-COVERED REVENUE CODE	16	M50
4084	SUBMITTED TO ALLOWED EXCEEDS PERCENT	125	M54
4089	MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED	96	M100
4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION	16	M76
4094	BPA-PC-REV - PROV COUNTY RESTRICTION	B7	
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL	45	
4097	INVALID/MISSING MODIFIER FOR THIS PROCEDURE	4	M78
4099	DRG NOT ON FILE	92	
4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION	16	M51
4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION	16	M50

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION	16	M76
4112	BPA-PC-ICD9 - FAMILY PLANNING IND RESTRICTION	16	M51
4113	UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY	92	
4114	PRICING BEING REVIEWED	133	M100
4117	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION	16	M119
4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION	16	M51
4120	ORAL CAVITY DESIGNATION CODE INVALID	16	N346
4127	CANNOT PRIORITIZE RECIPIENT'S PROGRAMS	133	
4128	ICD9 PROCEDURE 7-24 NOT ON FILE	16	
4130	PAYER HIERARCHY NOT FOUND	A1	M56
4131	NO BENEFIT PLANS ASSOCIATED TO PAYER	B7	
4132	DRG GROUPER UNABLE TO ASSIGN DRG FOR PRICING	92	
4136	BPA-RP-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16	M51
4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION	16	M119
4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	M51
4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	M51
4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	M50
4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	M50
4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16	M76
4145	BPA-PC-DRG - BILL PROV PRIMARY PT/PS RESTRICTION	16	
4146	BPA-PC-DRG - PERF PROV PRIMARY PT/PS RESTRICTION	16	
4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	M51
4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	M51
4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	M50
4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	M50
4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION	16	M50

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION	16	M77
4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION	B7	M76
4158	BPA-PC-DRG - CURR PROV CONTRACT RESTRICTION	16	
4159	BPA-PC-ICD9 - CURR PROV CONTRACT RESTRICTION	B7	M51
4160	BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION	B7	M119
4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION	B7	M51
4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION	B7	M50
4164	INACTIVE DRUG	96	
4165	Max Day Restriction for Covered NDC	16	
4166	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN	16	M119
4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN	16	M50
4177	BPA-PC-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16	N95
4190	BPA-RP-DRG - ANY HDR DIAGNOSIS RESTRICTION	16	
4191	BPA-PC-DRG - ANY HDR DIAGNOSIS RESTRICTION	16	
4192	BPA-RP-DRG - OTHER DTL DIAG RESTRICTION	16	
4194	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION	16	M51
4200	CLAIM PRICED AT ZERO	45	
4203	DENIAL MODIFIER SUBMITTED ON CLAIM	B7	
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	B7	MA120
4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD	B7	MA120
4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION	16	M76
4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE	16	N37
4212	BILLING OUT OF CLIA CERTIFICATE TYPE	B7	MA120
4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL	16	MA30
4224	BPA-RP-PROC - QUANTITY RESTRICTION	16	N362
4225	INVALID INPATIENT REVENUE CODE	16	M50
4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION	16	M81
4227	BPA-RP-REV - NO COVERAGE	16	M50
4231	BPA-PC-NDC - MAX UNIT RESTRICTION	16	
4233	DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION	16	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4236	INVALID USE OF EMERGENCY DIAGNOSIS CODE	16	
4237	INVALID TYPE OF LEAVE	16	
4240	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE	16	
4244	BPA-RP-DIAG - NO COVERAGE	16	M76
4245	FOURTH MODIFIER INVALID FOR DATE OF SERVICE	4	
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	45	M78
4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF	16	N95
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	16	M53
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	16	M64
4254	BPA-RP-REV - AGE RESTRICTION	6	M50
4255	BPA-PC-DRG - ADMIT DIAG RESTRICTION	16	
4256	BPA-RP-PROC - MODIFIER RESTRICTION	4	
4257	BPA-PC-PROC - MODIFIER RESTRICTION	4	
4258	BPA-PC-DRG - OCCURRENCE CODE RESTRICTION	16	
4260	NDC REQUIRED FOR PROCEDURE	16	M119
4261	INVALID UNIT OF MEASURE VALUE	16	
4262	NDC QUANTITY UNITS IS NOT NUMERIC	16	
4263	NDC QUANTITY UNITS IS ZERO	16	
4264	NDC NOT ON THE DRUG FILE	16	M119
4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC	16	M119
4266	PRIMARY NDC NO LONGER ACTIVE ON DATE OF SVC	16	M119
4267	SECONDARY NDC NO LONGER ACTIVE ON DATE OF SVC	16	M119
4268	PRIMARY NDC NOT REBATABLE ON THE DATE OF SERVICE	16	M119
4269	SECONDARY NDC NOT REBATABLE ON THE DATE OF SERVICE	16	M119
4270	NDC RATED LESS THAN EFFECTIVE	16	M119
4271	NDC REQUIRED FOR PROCEDURE	16	M119
4272	NDC OBSOLETE OR INVALID ON THE DATE OF SERVICE	16	M119
4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4	16	M119
4274	INVALID PRESCRIPTION QUALIFIER CODE, MUST EQUAL XZ	16	
4275	DRUG UNIT PRICE IS NOT NUMERIC	16	
4276	DRUG UNIT PRICE IS ZERO	16	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION	16	MA65
4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION	16	MA63
4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION	16	M64
4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION	16	N34
4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION	16	M76
4316	BPA-PC -ANY DTL DIAG RESTRICTION	16	M64
4317	BPA-PC-ICD9 - ADMIT DIAG RESTRICTION	16	MA65
4318	BPA-PC-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4319	BPA-PC-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16	M76
4320	BPA-PC-REV - ADMIT DIAG RESTRICTION	16	MA65
4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION	16	M76
4361	BPA - DIAGNOSIS RESTRICTION	16	M76
4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION	16	MA30
4363	BPA-PC-DRG - TYPE OF BILL RESTRICTION	16	MA30
4364	BPA-PC-ICD9 - TYPE OF BILL RESTRICTION	16	MA30
4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION	16	N34
4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION	16	M64
4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION	16	N34
4374	BPA-RP-REV - CLAIM TYPE RESTRICTION	16	N34
4376	BPA-RP-ICD9 - CLAIM TYPE RESTRICTION	16	N34
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	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
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-NDC - 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	M51
4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION	16	M50
4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION	16	M76
4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION	16	M119
4523	BPA-RP-ICD9 - BILL PROV ALL PT/PS RESTRICTION	16	M76
4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION	16	M51
4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION	16	M50
4526	BPA-PC-PROC - PROV COUNTY RESTRICTION	B7	
4527	BPA-PC-NDC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4529	BPA-RP-REV - PROV COUNTY RESTRICTION	B7	M50
4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION	16	M64
4532	BPA-RR-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
4534	BPA-RP-DRG - EMERGENCY DIAGNOSIS RESTRICTION	16	
4535	BPA-RP-ICD9 - EMERGENCY DIAGNOSIS RESTRICTION	16	M76
4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	M76
4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION	16	M76

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	M76
4540	BPA-PC-PROC - MIN UNIT RESTRICTION	16	M53
4541	BPA-RP-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4542	BPA-RP-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4545	BPA-RP-PROC - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4546	BPA-RP-REV - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4547	BPA-PC-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4548	BPA-PC-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4551	BPA-PC-PROC - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4552	BPA-PC-REV - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4553	BPA-RR-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4554	BPA-RR-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4556	BPA-RR-NDC - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4557	BPA-RR-PROC - REFER PROV PRIMARY PT/PS RESTRICTION	16	
4558	BPA-RR-REV - 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	M64
4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION	16	M64
4562	BPA-RP-REV - GENDER RESTRICTION	16	MA39
4563	BPA-RR - NO RULE CURR PERF PROV CONTRACT	B7	
4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION	16	M64
4565	BPA-RR-ICD9 - HDR SECONDARY DIAG RESTRICTION	16	M64
4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION	16	M64
4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP	16	MA63

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP	16	MA63
4711	BPA-PC-DIAG - AGE RESTRICTION	9	
4712	BPA-PC-DRG - AGE RESTRICTION	16	
4713	BPA-PC-NDC - AGE RESTRICTION	16	
4714	BPA-PC-PROC - AGE RESTRICTION	6	
4715	BPA-PC-REV - AGE RESTRICTION	6	
4716	BPA-PC-ICD9 - AGE RESTRICTION	16	M76
4721	BPA-RP-DRG - ADMIT DIAG RESTRICTION	6	
4722	BPA-RP-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION	16	
4723	BPA-RP-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA36
4724	BPA-RP-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16	M64
4726	BPA-RP-ICD9 - ADMIT DIAG RESTRICTION	16	MA65
4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION	16	M64
4732	BPA-RP-REV - ADMIT DIAG RESTRICTION	16	MA65
4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION	16	M64
4734	BPA-PC-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA36
4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION	16	MA65
4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	MA63
4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION	16	M64
4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION	16	M64
4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION	16	M64
4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION	16	MA63
4747	BPA-PC-ICD9 - HDR SECONDARY DIAG RESTRICTION	16	M64
4748	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION	16	M64
4751	BPA-PC-REV - TYPE OF BILL RESTRICTION	16	MA30
4755	BPA-PC-PROC - CURRENT BENEFIT PLAN RESTRICTION	16	
4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION	16	M76
4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION	16	M50

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4762	BPA-PC-ICD9 - PLACE OF SERVICE RESTRICTION	16	M77
4765	BPA-RP-ICD9 - NO COVERAGE	16	M64
4766	BPA-RP-ICD9 - AGE RESTRICTION	9	
4767	BPA-RP-ICD9 - PLACE OF SERVICE RESTRICTION	16	M77
4775	BPA-PC-NDC - 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	M51
4802	BPA-PC-DIAG - NO CONTRACT	16	M76
4803	BPA-PC-NDC - NO CONTRACT	16	
4804	BPA-PC-REV - NO CONTRACT	16	M50
4805	BPA-PC-DRG - NO CONTRACT	16	
4806	BPA-PC-ICD9 - NO CONTRACT	16	M64
4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION	16	M77
4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION	16	M77
4831	BPA-RR - NO REIMB RULE	16	
4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION	16	M64
4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION	16	N34
4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION	16	N34
4873	BPA-PC-NDC - CLAIM TYPE RESTRICTION	16	N34
4874	BPA-PC-REV - CLAIM TYPE RESTRICTION	16	N34
4875	BPA-PC-DRG - CLAIM TYPE RESTRICTION	16	
4876	BPA-PC-ICD9 - CLAIM TYPE RESTRICTION	16	N34
4881	BPA-PC-DRG - PLACE OF SERVICE RESTRICTION	16	
4882	BPA-RP-DRG - NO COVERAGE	16	
4884	BPA-RP-DRG - AGE RESTRICTION	16	
4886	BPA-RP-DRG - CLAIM TYPE RESTRICTION	16	
4887	BPA-RP-DRG - PLACE OF SERVICE RESTRICTION	16	
4900	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION	16	M76
4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION	16	M44
4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION	16	M45
4904	BPA-RP-DRG - OTHER HDR DIAGNOSIS RESTRICTION	16	
4905	BPA-RP-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	M64

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION	16	M76
4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION	16	M44
4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION	16	M45
4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR	16	M45
4917	BPA-PC-DRG - OTHER HDR DIAGNOSIS RESTRICTION	16	
4920	BPA-RP-DRG - BENE PLAN RESTRICTION	16	N208
4921	BPA-RP-DRG - CONDITION CODE RESTRICTION	16	M44
4922	BPA-RP-DRG - OCCURRENCE CODE RESTRICTION	16	M45
4923	BPA-PC-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16	M64
4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION	16	M76
4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION	16	M51
4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION	16	M50
4930	BPA-PC-DRG - BENEFIT PLAN RESTRICTION	16	N208
4931	BPA-PC-DRG - CONDITION CODE RESTRICTION	16	M44
4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	M76
4935	BPA-RP-DRG - GENDER RESTRICTION	16	MA39
4936	BPA-PC-DRG - GENDER RESTRICTION	16	MA39
4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION	16	M76
4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION	16	M51
4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION	16	M50
4940	BPA-RP-ICD9 - BENE PLAN RESTRICTION	16	M76
4941	BPA-RP-ICD9 - CONDITION CODE RESTRICTION	16	M44
4942	BPA-RP-ICD9 - OCCURRENCE CODE RESTRICTION	16	M45
4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	M76
4944	BPA-PC-ICD9 - GENDER RESTRICTION	16	MA39
4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION	16	M119
4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION	16	M51
4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION	16	M50
4950	BPA-PC-ICD9 - BENEFIT PLAN RESTRICTION	16	M76
4951	BPA-PC-ICD9 - CONDITION CODE RESTRICTION	16	M44
4952	BPA-PC-ICD9 - OCCURRENCE CODE RESTRICTION	16	M45

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
4953	BPA-RR-DRG - OTHER DTL DIAG RESTRICTION	16	
4960	BPA-RP-NDC - BENE PLAN RESTRICTION	16	M119
4961	BPA-RP-PROC - PROV COUNTY RESTRICTION	16	M51
4962	BPA-PC-NDC - GENDER RESTRICTION	16	MA39
4963	BPA-PC-PROC - GENDER RESTRICTION	16	MA39
4964	BPA-PC-REV - GENDER RESTRICTION	16	MA39
4965	BPA-PC-NDC - BENEFIT PLAN RESTRICTION	16	M119
4966	BPA-RR - DIAGNOSIS RESTRICTION	16	M76
4970	BPA-RP-REV - BENEFIT PLAN RESTRICTION	16	M50
4971	BPA-RP-REV - CONDITION CODE RESTRICTION	16	M44
4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION	16	M45
4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION	16	M64
4975	BPA-PC-REV - BENEFIT PLAN RESTRICTION	16	M50
4976	BPA-PC-REV - CONDITION CODE RESTRICTION	16	M44
4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION	16	M45
4980	BPA-RP-PROC - BENEFIT PLAN RESTRICTION	16	
4981	BPA-RP-PROC - CONDITION CODE RESTRICTION	16	M44
4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION	16	M45
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	M44
4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION	16	M45
4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION	16	M76
4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP	96	N30
5000	OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL	18	
5001	OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL	18	
5002	OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL	18	
5005	DENTAL DUPLICATE EXACT	18	
5006	OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL	18	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5010	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18	
5011	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	
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	
5017	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18	
5018	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 NUMBER FOR SAME DATE OF SERVICE.	18	
5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	N20
5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	N20
5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE	B5	N20
5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCE	B5	N20
5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	N20
5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	N20
5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	N20
5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	N20
5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	N20
5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	N20
5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	N20
5212	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518	B5	N20
5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518	B5	N20
5214	PROCEDURE CODE NOT ALLOWED ON THE SAME DAY	B5	N20
5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	N20
5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	N20
5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	N20
5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	N20
5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	N59
5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	N59
5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED	119	N59
5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	N59
5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	N59
5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	N20
5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	N20
5260	BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI	119	
5261	BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI	119	
5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE	B5	N20
5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY	B5	N20
5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	N59
5314	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5315	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5316	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5317	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5318	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5319	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5320	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5321	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5322	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5323	PULP THERAPY COMBINATION NOT ALLOWED	B5	N59
5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	N59
5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	N59
5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	N39
5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	N39
5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	N39
5329	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	N39
5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	N20
5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	N20
5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	N20
5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	N20
5334	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	N20
5335	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	N20
5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.	97	N59
5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.	119	N59
5340	ORAL EVALUATION < 3 YRS (D0145) CONTRA	18	
5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.	107	N59
5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.	B5	N59
5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	N384

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	N384
5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	N20
5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	N20
5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	N20
5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	N20
5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	N20
5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	N20
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 SERVIC	119	N59
5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC	119	N59
5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	N20
5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	N20
5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	N20
5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	N20
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	B5	N20
5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC	B5	N20
5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	N20
5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
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	N20
5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	N20
5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	N20
5439	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLEDON THE SAME DAY.	B5	N20
5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	N59
5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	N59
5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME	B5	N59
5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	N20
5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	N20
5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).	97	N59
5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	N20
5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	N20
5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	N20
5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	N20
5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	N20
5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	N20
5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	N20
5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	N20
5480	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5481	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5482	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5483	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.	B5	N59
5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE	B5	N59
5488	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	N20
5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	N20
5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	N20
5506	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	M83
5507	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	M83
5508	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	N59
5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	N59
5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY	119	N59
5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	119	N20
5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5	N20
5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	N20
5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	N20
5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	N20
5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	N20
5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	N20
5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	N20
5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	N59
5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	N59
5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	N20
5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	N20
5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	N59
5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	N59
5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	N20
5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	N20
5602	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	N19
5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	N19

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5606	PAYMENT MADE FOR SIMILAR PROCEDURE	97	N20
5607	PAYMENT MADE FOR SIMILAR PROCEDURE	97	N20
5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	M86
5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	M86
5610	PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC	B5	N20
5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.	B5	N20
5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	N20
5613	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	N20
5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	N20
5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	N20
5616	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	N20
5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	N20
5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	N20
5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	N20
5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLEDTOGETHER.	B5	N20
5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	N20
5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	N20
5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	N20
5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	N20
5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	N20
5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	N20
5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	M86
5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	M86
5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	N20
5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	N20
5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER	97	N20
5633	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY	97	N20
5634	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	N20
5635	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	N20
5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	N20
5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	N20
5638	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	N20
5639	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	N20
5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	N20
5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	N20
5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	N59
5643	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	N59
5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	N20
5646	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH	97	N59
5647	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH	97	N59
5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)	B5	N20
5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY	B14	N20
5652	ONLY ONE INITIAL NICU PROCEDURE MAY BE BILLED PER HOSPITAL STAY.	119	
5654	PROCEDURE CODE IS LIMITED TO ONE IN A SERIES	119	
5655	MULTIPLE SURGERY CONTRAS	18	
5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	N20
5658	A CARDIOLOGIST OR A RADIOLOGIST CANNOT BILL THIS PROCEDURE CODE ON THE SAME DAY	18	
5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY	B14	N59
5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITAL CARE.	B5	N390
5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	N20
5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	N20
5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPENT	B5	N20
5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPENT	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	N20
5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	N20
5724	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5725	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	N20
5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	N20
5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	N20
5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	N20
5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	N20
5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	N20
5733	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	N20
5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	N20
5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	N20
5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	N20
5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	N20
5740	INDIVIDUAL THERAPY AND GROUP THERAPY MAY NOT BE BILLED ON THE SAME DAY.	B14	N20
5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	N20
5751	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	N20

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	N20
5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	N20
5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	M86
5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	M86
5760	ESWL PRICING	45	N59
5770	INDEPENDENT RURAL HEALTH CLINICS CANNOT BE PAID FOR MORE THAN ONE SERVICE PER D	119	
5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA	119	N20
5791	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	N20
5792	PHYSICAL THERAPY APPLIANCES CONTRA	119	N20
5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	N20
5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	N20
5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	N20
5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	N20
5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.	18	N20
5812	POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO	B5	
5813	POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO	B5	
5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.	97	N390
5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI	97	N390
5816	HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.	B5	N390

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	N362
5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.	B5	N390
5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.	B5	N390
5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO	B5	N59
5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	N59
5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	N59
6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON	119	N59
6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR	119	N59
6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.	119	N59
6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.	119	N59
6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.	119	N59
6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS	119	N59
6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.	119	N59
6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.	119	N59
6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119	N59
6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT	119	N59
6041	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	N59
6042	PROCEDURE LIMITED TO ONCE EVERY 30 DAYS.	119	N59
6043	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6044	EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.	119	N59
6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.	119	N117
6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS	119	N59
6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS	119	N59
6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS	119	N59
6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.	119	N59
6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS	119	N59
6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS	119	N59
6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION	15	M62
6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.	119	N117
6054	ORAL EVALUATION < 3 YRS (D0145)	18	
6056	FLOURIDE VARNISH < 3YRS - LIMIT 3 PER CAL YEAR	18	
6057	FLOURIDE VARNISH < 3YRS - LIMIT 6 TOTAL	18	
6058	FLOURIDE VARNISH > 3YRS - LIMIT 1 PER CAL YEAR	18	
6100	PROCEDURE IS LIMITED TO SIXTY (60) PER CALENDAR MONTH.	119	N59
6101	PROCEDURE IS LIMITED TO TWENTY (20) PER CALENDAR MONTH.	119	N59
6102	PROCEDURE IS LIMITED TO ONE (1) EVERY FIVE YEARS	119	N59
6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.	119	N59
6104	PROCEDURE CODE IS LIMITED TO ONE-HUNDRED (100) PER MONTH.	119	N59
6105	PROCEDURE IS LIMITED TO 60 (SIXTY) TIMES PER CALENDAR MONTH	119	N59
6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119	N59
6107	PROCEDURE CODE IS LIMITED TO 40 (FORTY) PER CALENDAR MONTH	119	N59
6108	PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS	119	N59
6109	PROCEDURE CODE IS LIMTED TO 100 PER MONTH	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	N59
6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	N59
6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	N59
6113	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119	N59
6114	PROCEDURE IS LIMITED TO TWO PER YEAR.	119	N59
6115	MEDICAL SUPPLIES LIMIT IS $1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA	119	N59
6116	PROCEDURE IS LIMITED TO ONE (1) EVERY FOUR CALENDAR YEARS.	119	N59
6117	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	N59
6118	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	N59
6119	PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS	119	N59
6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.	119	N59
6121	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6122	LEG BAGS ARE LIMITED TO TWO PER MONTH	119	N59
6123	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6124	PROCEDURE IS LIMITED TO ONE (1) EVERY THREE YEARS.	119	N59
6125	CATHETERS, CATHETER TRAYS, AND DRAINAGE BAGS ARE LIMITED TO TWO PER MONTH.	119	N59
6126	PROCEDURE IS LIMITED TO ONE HUNDRED TWENTY (120) PER CALENDAR MONTH.	119	N59
6150	VISION AND HEARING SCREENING ONE PER YEAR	119	N59
6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME	119	N59
6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	N59
6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	N59
6154	MAXIMUN UNIT LIMIT HAS BEEN EXCEEDED.	119	N59
6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.	119	N59
6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	N59
6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED	119	N59
6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	N59
6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED	119	N59
6200	THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.	119	N59
6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR.	119	N59
6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.	119	N59
6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME	119	N59
6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR	119	N59
6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977	119	N59
6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O	B5	N59
6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.	119	N59
6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	119	N59
6230	MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE SAME DATE OF SERV	B14	N20
6231	MORE THAN ONE DENTAL ENCOUNTER (D9430)CANNOT BE PAID ON THE SAME DATE OF SERVIC	B14	N20
6240	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6241	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6242	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6243	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6244	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6245	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6246	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6247	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6248	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6249	HBO LIMIT HAS BEEN EXCEEDED	119	N59
6260	NUMBER OF HOME HEALTH VISITS EXCEED LIMIT	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6280	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR	119	N59
6281	OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR.	119	N59
6282	INPATIENT DAYS HAVE BEEN EXEEDED FOR THIS CALENDAR YEAR.	119	N59
6283	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	N59
6290	MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY	B5	N20
6291	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	N59
6300	THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS.	119	N59
6301	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED W ITHIN SIX MONTHS	119	N59
6302	MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS.	B5	N59
6303	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS.	B5	N59
6310	THE QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED FOR THE DRUG CODE P	16	
6311	QTY DISPENSED EXCEEDS MAX QTY BASED ON PA	16	M123
6312	MONTHLY SCRIPT LIMIT EXCEEDED	119	
6313	MONTHLY SCRIPT LIMIT EXCEEDED - BRANDED DRUG	119	
6314	MONTHLY SCRIPT LIMIT EXCEEDED	119	
6400	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	N20
6401	OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUI	119	N59
6402	SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR	119	N59
6403	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR.	119	N59
6404	PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER	119	N59
6405	PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS	119	N59
6406	NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6407	THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIP	119	N59
6408	PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT	B14	N59
6409	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	N59
6410	PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED	119	N59
6411	INITIAL CRITICAL CARE LIMITED TO ONE PER DAY	119	N59
6412	ER AND CRITICAL CARE CODE ONE PER CLAIM.	B5	N20
6413	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	N59
6510	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6511	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6512	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6513	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6514	THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR.	119	N59
6515	THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR	119	N59
6516	THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR	119	N59
6517	THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR	119	N59
6518	PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR.	119	N59
6519	PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR	119	N59
6520	PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR.	119	N59
6521	THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR.	119	N59
6522	THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR.	119	N59
6523	BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR YEAR.	119	N59
6524	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	N59
6525	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6526	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	N59
6527	BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR YEAR.	119	N59
6528	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	N59
6529	PROCEDURE IS LIMITED TO 260 UNITS A YEAR.	119	N59
6530	PROCEDURE IS LIMITED TO 8 UNITS A YEAR.	119	N59
6531	PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR.	119	N59
6532	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR.	119	N59
6533	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR	119	N59
6534	PROCEDURE IS LIMITED TO 2016 UNITS A YEAR.	119	N59
6535	PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR.	119	N59
6536	PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR.	119	N59
6537	PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR.	119	N59
6538	YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED	119	N59
6539	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6540	PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF	119	N59
6541	DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR	119	N59
6542	PROCEDURE IS LIMITED TO 4160 UNITS A YEAR.	119	N59
6600	RADIOLOGY - PROCEDURE REQUIRES PRIOR AUTHORIZATION	197	
6610	DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER	119	N59
6611	PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR.	119	N59
6612	PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH.	119	N59
6613	PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME.	119	N59
6630	THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH.	119	N59
6640	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6641	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
6642	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6643	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6644	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6645	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6646	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	N59
6647	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6650	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THIS CONTRACT YEAR	119	N59
6651	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119	N59
6652	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119	N59
6653	PROCEDURE LIMITED TO 1080 HOURS,PER WAIVER YEAR OCTOBER 1 - SEPTEMBER 30.	119	N59
6670	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	N59
6671	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS RECIP	18	
6672	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	
6673	PROCEDURE IS LIMITED TO ONE (1) EVERY TWO YEARS.	119	N59
6674	CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL.	18	
6677	PROCEDURE CODE CANNOT BE BILLED MORE THAN SIX(6) TIMES WITH THE SAME MODIFIER.	18	M86
6690	REVENUE CODE 183 IS LIMITED TO 6 DAYS EACH CALENDAR QUARTER.	119	N43
6691	REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDAR MONTH	119	N43
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	
7200	MISCELLANEOUS CLAIMCHECK ERROR	6	
7201	PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR	6	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
7202	PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS	6	
7203	PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS	6	
7204	PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS	6	
7205	PROCEDURE IS NOT INDICATED FOR A MALE	7	
7206	PROCEDURE IS NOT INDICATED FOR A FEMALE	7	
7207	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE	96	
7208	PROCEDURE IS AN UNLISTED PROCEDURE	96	
7209	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL	96	
7210	PROCEDURE IS CLASSIFIED AS OBSOLETE	96	
7211	PROCEDURE IS INVALID FOR PATIENT'S AGE	6	
7213	PROCEDURE IS INVALID FOR PATIENT'S SEX	7	N22
7214	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX)	7	MA39
7215	PROCEDURE CODE IS INCIDENTAL	125	N22
7216	VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT	96	N19
7217	PROCEDURE CODE HAS BEEN REBUNDLED	125	
7218	PROCEDURE ADDED DUE TO REBUNDLING	125	
7219	PROCEDURE IS MUTUALLY EXCLUSIVE	125	N22
7220	PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE	B13	
7221	PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE	B13	M144
7222	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON	4	M144
7223	PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON	4	
7233	DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL	18	
7234	DENIED DUPLICATE - IS BILATERAL	18	
7235	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME	18	
7236	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY	18	
7237	DENIED DUPLICATE (REBUNDLED)	18	
7238	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING	125	
7239	PROCEDURE IS A POSSIBLE DUPLICATE	18	N22
7240	SMARTSUSPENSE SUSPEND	45	
7241	SMARTSUSPENSE DENIAL	16	

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
7242	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED	11	
7243	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED	11	
7244	MEDICAL VISIT DENIED	16	
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT	16	
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT	16	N22
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT	16	N22
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS	11	N22
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT	18	
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT	18	
7251	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	B20	
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	B20	
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	B20	
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	B20	
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	B20	
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE	4	
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE	4	
7258	REVIEW MODIFIER 51	4	
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS	35	
7260	MORE THAN 40 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING	35	
7261	INVALID PROCEDURE CODE	96	
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE	14	N56
7263	DOS REQUIRED FOR PROCEDURE	16	
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES	125	
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION	4	M78

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA REMARK CODE
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID	125	M78
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE	11	
7278	INVALID DATE (DATE OF BIRTH)	16	
7279	INVALID AMOUNT CHARGED	125	M38
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED	125	MA54
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE	11	
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS	11	
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT	45	
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT	133	
7285	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	B20	
7286	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	B20	
7287	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	92	
7288	SMARTSUSPENSE FLAG	133	M100
7289	SMARTSUSPENSE MONITOR	133	
7290	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE	4	
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE	4	
7500	REVIEW CLAIM FOR PAY-TO- PROVIDER	16	
7503	CONFLICT CODE ON RESPONSE CLAIM DOES NOT MATCH	16	
7509	REVIEW CLAIMS FOR THIS PROVIDER	133	
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	45	
9999	PROCESSED PER MEDICAID POLICY	45	