



J. Provider Remittance Advice (RA) 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

Appendix J as of 03/26/2014

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
201	INVALID PAY-TO PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N280	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER.
203	RECIPIENT I.D. NUMBER MISSING	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.
204	RECIPIENT ID - OLD FORMAT	A1	Claim/Service denied.	N382	Missing/incomplete/invalid patient identifier.
206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.
212	MISSING PRESCRIPTION NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N388	Missing/incomplete/invalid prescription number.
215	DATE DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
216	DATE DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
217	MISSING DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
218	INVALID DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
219	QUANTITY DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N378	Missing/incomplete/invalid prescription quantity.
220	QUANTITY DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N378	Missing/incomplete/invalid prescription quantity.
223	MISSING DIAGNOSIS INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
224	DIAGNOSIS TREATMENT INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
225	REFERRING PROVIDER - INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
233	UNITS OF SERVICE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
234	PROCEDURE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
235	PROCEDURE CODE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
236	NO PROCEDURE FOR REVENUE CODE; MEDICAID HAS NO PAYMENT LIABILITY FOR THIS LINE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
239	DETAIL TO DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M59	Missing/incomplete/invalid to date(s) of service.
240	THE DETAIL "TO" DATE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M59	Missing/incomplete/invalid to date(s) of service.
243	MISSING MEDICARE PAID DATE	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
248	PLACE OF SERVICE IS MISSING OR BLANK	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
249	PLACE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
250	CLAIM HAS NO DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
255	PATIENT RSN FOR VISIT REQ ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
256	ADMIT DIAGNOSIS INVALID ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
257	PATIENT RSN FOR VISIT INVALID ON INPATIENT CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
258	MISSING DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
260	UNITS OF SERVICE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
261	MISSING TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
262	INVALID TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
263	INVALID TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.
264	DETAIL FROM DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
265	DETAIL FROM DATE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
266	MISSING TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
268	BILLED AMOUNT INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M79	Missing/incomplete/invalid charge.
269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M79	Missing/incomplete/invalid charge.
270	MISSING TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
271	INVALID TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
273	TYPE OF BILL MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
274	TYPE OF BILL CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
275	ADMIT DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA40	Missing/incomplete/invalid admission date.
276	ADMIT DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA40	Missing/incomplete/invalid admission date.
277	INVALID ADMISSION HOUR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N46	Missing/incomplete/invalid admission hour.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
278	ADMIT TYPE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA41	Missing/incomplete/invalid admission type.
279	INVALID TYPE OF ADMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA41	Missing/incomplete/invalid admission type.
280	PATIENT STATUS IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA43	Missing/incomplete/invalid patient status.
281	PATIENT STATUS IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA43	Missing/incomplete/invalid patient status.
282	MISSING COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.
283	COVERED DAYS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.
284	PRIMARY CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
285	SECOND CONDITON CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
286	THIRD CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
287	FOURTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
288	FIFTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
289	SIXTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
290	SEVENTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
296	DATE FOR PRIMARY OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
297	DATE FOR SECOND OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
298	DATE FOR SECOND OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
299	DATE FOR THIRD OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
300	DATE FOR THIRD OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
301	DATE FOR FOURTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
302	DATE FOR FOURTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
306	BOTH ICD-9 AND ICD-10 CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
307	BOTH ICD-9 AND ICD-10 PROC CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
308	BOTH ICD-9 AND ICD-10 DIAG CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
309	ICD PROCEDURE VERSION INVALID FOR COMPLIANCE DATES	181	PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
310	ICD DIAGNOSIS VERSION INVALID FOR COMPLIANCE DATES	146	Diagnosis was invalid for the date(s) of service reported.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
339	REVENUE CODE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
340	REVENUE CODE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
364	PRINCIPAL ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N303	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE DATE.
365	PRINCIPAL ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N303	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE DATE.
367	FIRST OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
368	FIRST OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
369	SECOND OTHER PROCEDURE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S)
370	SECOND OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
371	SECOND OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
373	THIRD OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
374	THIRD OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
376	FOURTH OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
377	FOURTH OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
379	FIFTH OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
380	FIFTH OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N253	MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER PRIMARY IDENTIFIER.
395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
411	DATE FOR FIFTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
412	DATE FOR FIFTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
413	DATE FOR SIXTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
414	DATE FOR SIXTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).

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EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
433	MEDICARE DEDUCTIBLE AMOUNT INVALID	1	DEDUCTIBLE AMOUNT	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.
450	INVALID QUADRANT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N346	Missing/incomplete/invalid oral cavity designation code.
455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
465	DATE FOR OCCURRENCE CODE 9-24 MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
466	DATE FOR OCCURRENCE CODE 9-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
471	CONDITION CODE 8-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever	M44	Missing/incomplete/invalid condition code.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate		
473	ICD PROCEDURE 7-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
474	ICD PROCEDURE 7-24 OR DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).
475	ICD PROCEDURE 7-24 DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).
500	DATE PRESCRIBED AFTER BILLING DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N57	MISSING/INCOMPLETE/INVALID PRESCRIBING DATE.
502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
503	DATE DISPENSED AFTER BILLING DATE	110	BILLING DATE PREDATES SERVICE DATE.	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	M46	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE.
513	NAME ON CLAIM MUST MATCH NAME	140	Patient/Insured health identification number and	MA36	Missing/incomplete/invalid patient name.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	ON FILE		name do not match.		
514	DATE RECEIVED FOR PROCESSING- PRIOR TO DATE OF SERV	110	BILLING DATE PREDATES SERVICE DATE.	M59	Missing/incomplete/invalid to date(s) of service.
519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE	110	BILLING DATE PREDATES SERVICE DATE.	MA40	Missing/incomplete/invalid admission date.
526	DETAIL DATES NOT WITHIN HEADER DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
557	MEPD LATE FILING	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.
570	TOTAL DAYS LESS THAN COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.
571	SURGICAL PROCEDURE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
574	SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N341	MISSING/INCOMPLETE/INVALID SURGERY DATE.
577	DETAIL SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
589	ADJUSTMENT HAS AUTO DENIAL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M85	Subjected to review of physician evaluation and management services.
595	MANUALLY SUSPEND FOR REVIEW	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M85	Subjected to review of physician evaluation and management services.
596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	129	Payment denied - Prior processing information appears incorrect.	N61	Rebill services on separate claims.
602	UNITS NOT EQUAL TO TEETH BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
606	INVALID OTHER PAYER DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
620	TPL DEDUCTIBLE AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
621	TPL COINSURANCE AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
622	TPL COPAY AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
623	TPL PAID AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
624	TPL DETAIL PAYER DOES NOT HAVE MATCHING HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
625	TPL DETAIL PAYER HAS MULTIPLE MATCHING HDR PAYERS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
626	TPL DETAIL PAYER ID HAS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
627	TPL HDR COINSURANCE <> SUM OF DTL COINSURANCE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
628	TPL HDR DEDUCTIBLE NOT EQUAL SUM OF DTL DEDUCTIBLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
629	TPL HDR COPAY NOT EQUAL SUM OF DTL COPAY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
630	TPL HDR PAID AMT NOT EQUAL SUM OF DTL PAID AMT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
631	TPL - PATIENT RESPONSIBILITY IS ZERO FOR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
632	TPL HDR PAYER HAS NO DETAIL PAYER INFORMATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
633	TPL HDR PAYER ID IS DUPLICATE OF ANOTHER HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
634	TPL PAYER RESPONSIBILITY MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
635	TPL PAYER RESPONSIBILITY HIERARCHY IS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
636	TPL TOTAL PAID AMT NOT EQUAL SUM OF HDR PAID AMT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
637	CLAIM WITH TPL AMOUNT MISSING TPL PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
643	INVALID OTHER COVERAGE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N245	INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE.
644	OTHER PAYER PAT RESP AMT IS INVALID	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
645	OTHER PAYER PAT RESP QUALIFIER IS INVALID	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
675	ADJ - RECIPIENT ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N382	Missing/incomplete/invalid patient identifier.
676	ADJ - PROVIDER ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N77	Missing/incomplete/invalid designated provider number.
677	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
678	ADJ - ORIGINAL ICN NOT SUBMITTED	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
679	ADJ - REQUEST RECIPIENT ID NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N382	Missing/incomplete/invalid patient identifier.
680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.
681	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.
685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
686	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
687	CANNOT ADJUST THIS CLAIM DUE TO PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M56	Missing/incomplete/invalid payer identifier.
800	DETAIL RATE NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M79	Missing/incomplete/invalid charge.
801	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M79	Missing/incomplete/invalid charge.
803	DATED EXCEED SOBRA/QMB ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
805	NONCOVERED CHARGE IS NOT NUMERIC	96	Non-covered charge(s).	M79	Missing/incomplete/invalid charge.
806	MEDICARE PAID AMOUNT MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
807	INVALID TPL ADJUDICATION DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
808	TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA35	Missing/incomplete/invalid number of lifetime reserve days.
811	HEADER FROM DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M52	Missing/incomplete/invalid from date(s) of service.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
812	ADMIT DATE IS GREATER THAN ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA40	Missing/incomplete/invalid admission date.
813	MEDICARE PAID DATE > ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
814	DETAIL TO DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M59	Missing/incomplete/invalid to date(s) of service.
815	SURGICAL ICD REQUIRES OPERATING PHYSICIAN	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N262	MISSING/INCOMPLETE/INVALID OPERATING PROVIDER PRIMARY IDENTIFIER.
816	COINSURANCE DAYS NOT NUMERIC	2	Coinsurance Amount	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
817	INVALID COINSURANCE DAYS	2	Coinsurance Amount	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
818	LIFETIME RESERVE DAYS NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA35	Missing/incomplete/invalid number of lifetime reserve days.
819	LIFETIME RESERVE DAYS > MAX ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA35	Missing/incomplete/invalid number of lifetime reserve days.
820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N61	Rebill services on separate claims.
821	NON-COVERED DAYS MISSING OR NOT NUMERIC	78	Non-Covered days/Room charge adjustment.	MA33	Missing/incomplete/invalid noncovered days during the billing period.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
822	SURGICAL REVENUE CODE REQUIRES ICD SURGERY CODE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S)
823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N382	Missing/incomplete/invalid patient identifier.
825	MEDICARE ALLOWED AMOUNT MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.
826	TYPE OF BILL INVALID FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.
840	ICD-10 CLAIM SPANS ICD-10 START DATE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
841	ICD-9 CLAIM SPANS ICD-9 END DATE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
902	PROCEDURE CODE GROUP NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N55	Procedures for billing with group/referring/performing providers were not followed.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N188	The approved level of care does not match the procedure code submitted.
906	GROUP NUMBER NOT FOUND IN ICD GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
909	GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
916	GROUP NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
917	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
919	GROUP NUMBER NOT FOUND IN AID CODE TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N216	PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.
921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
924	SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND	63	Correction to a prior claim.	M47	Missing/incomplete/invalid internal or document control number.
925	GROUP NUMBER NOT FOUND IN REFERENCE GROUP TABLE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
1000	NO PAY-TO PROVIDER RECORD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N279	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER NAME.
1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.
1002	PERFORMING PROV NOT ELIGIBLE FOR DOS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N277	MISSING/INCOMPLETE/INVALID OTHER PAYER RENDERING PROVIDER IDENTIFIER.
1003	PROVIDER INELIGIBLE ON DATE OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.
1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1010	PERFORMING PROVIDER NOT IN BILLING GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N55	Procedures for billing with group/referring/performing providers were not followed.
1018	CLINIC RATE NOT ON FILE FOR HOSPITAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV	38	Services not provided or authorized by designated (network/primary care) providers.	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.
1032	PROVIDER TYPE - CLAIM INPUT CONFLICT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
1038	DEA NOT ON FILE FOR PRESCRIBER	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1041	PRESCRIBER PRACTICE TYPE NOT VALID FOR DRUG SCHED	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N277	MISSING/INCOMPLETE/INVALID OTHER PAYER RENDERING PROVIDER IDENTIFIER.
1054	ORDERING PROVIDER NOT ON FILE	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1065	PROVIDER NAME MISMATCH	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N279	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER NAME.
1079	ORDERING PROV NOT ENROLLED SVC LOCATION	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1100	ORDERING PROV - STATUS NOT VALID FOR DOS	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N55	Procedures for billing with group/referring/performing providers were not followed.
1804	VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N55	Procedures for billing with group/referring/performing providers were not followed.
1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N95	This provider type/provider specialty may not bill this service.
1807	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
1810	PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N95	This provider type/provider specialty may not bill this service.
1815	PERF PROV ENROLL STATUS NOT VALID FOR DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
1819	INVALID POS FOR FQHC PROVIDER	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service.
1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL	38	Services not provided or authorized by designated (network/primary care) providers.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1825	COBA DENIAL - DO NOT CROSSOVER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
1826	SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
1827	NON-MEPD CLAIM FOR MEPD RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M115	This item is denied when provided to this patient by a non-demonstration supplier.
1830	PROCEDURE REQUIRES BOTH ORDERING AND REF PROVIDER	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1831	PROCEDURE REQUIRE EITHER ORDERING OR REF PROVIDER	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1832	PROCEDURE REQUIRES REFERRING PROVIDER	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1833	PROCEDURE REQUIRES ORDERING PROVIDER	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1900	TAXONOMY IS INVALID BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1901	TAXONOMY IS INVALID PREFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1907	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1912	TAXONOMY IS MISSING: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1913	TAXONOMY IS MISSING: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1927	BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N	206	National Provider Identifier - missing	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.
1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N253	MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER PRIMARY IDENTIFIER.
1961	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N262	MISSING/INCOMPLETE/INVALID OPERATING PROVIDER PRIMARY IDENTIFIER.
1962	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
1968	NPI REQUIRED: ORDERING PROVIDER (HEALTHCARE)	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1969	INVALID DTL ORDERING PROVIDER OVERRIDE SPECIFIED	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.
1974	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1975	TAXONOMY IS INVALID: DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1976	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1977	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1978	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1979	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1980	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1981	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1982	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1983	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1984	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1985	TAXONOMY IS INVALID: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1986	TAXONOMY IS INVALID: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1987	TAXONOMY IS INVALID: REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1988	TAXONOMY IS INVALID: FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1989	TAXONOMY IS INVALID: OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.
2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
2053	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.
2057	RECIPIENT PARTIALLY ELIGIBLE - HEADER	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
2504	FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTAC HMNT)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2507	THIS PATIENT HAS TWO COVERAGE TYPES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2804	DETAILS COVERED BY MORE THAN ONE PLAN CODE	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
2807	COBA-NO MEDICAID ID FOR MEDICARE ID	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.
2808	COBA - MEDICARE ID NOT ON FILE	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
2850	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2851	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2852	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
3019	PA CUTBACK PERFORMED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N123	This is a split service and represents a portion of the units from the originally submitted service.
3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M76	Missing/incomplete/invalid diagnosis or condition.
3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M50	Missing/incomplete/invalid revenue code(s).
3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION	5	The procedure code/bill type is inconsistent with the place of service.	MA30	Missing/incomplete/invalid type of bill.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
3313	NDC DRUG, PRODUCT IS NOT PREFERRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M62	Missing/incomplete/invalid treatment authorization code.
3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3315	NURSERY DAYS EXCEED LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
3351	PRIMARY DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
3352	SECOND DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3353	THIRD DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3354	FOURTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3355	FIFTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
3356	SIXTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3357	SEVENTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3358	EIGHTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3359	NINTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4001	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.
4002	BPA-RP-NDC - NO COVERAGE	96	Non-covered charge(s).	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4004	NDC IS NOT ON FILE	96	Non-covered charge(s).	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4013	PROCEDURE CODE IS NO LONGER VALID	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4014	NO PRICING SEGMENT IS ON FILE.	133	The disposition of this claim/service is pending further review.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.
4021	BPA-RP-PROC - NO COVERAGE	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4032	PROCEDURE CODE IS MISSING/NOT ON FILE	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4038	PATIENT REASON FOR VISIT DIAGNOSIS NOT ON FILE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	96	Non-covered charge(s).	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4059	REVENUE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4061	BPA-RR - NO RULE FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4062	BPA-RR - NO RULE FOR COND CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4064	BPA-RP-ICD - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4075	BPA-RP-ICD - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4077	NON-COVERED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4112	BPA-PC-ICD - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4117	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4120	ORAL CAVITY DESIGNATION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N346	Missing/incomplete/invalid oral cavity designation code.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4130	PAYER HIERARCHY NOT FOUND	A1	Claim/Service denied.	M56	Missing/incomplete/invalid payer identifier.
4136	BPA-RP-ICD - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M76	Missing/incomplete/invalid diagnosis or condition.
4159	BPA-PC-ICD - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4160	BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4166	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4177	BPA-PC-ICD - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
4194	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.
4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.
4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
4212	BILLING OUT OF CLIA CERTIFICATE TYPE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4224	BPA-RP-PROC - QUANTITY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
4225	INVALID INPATIENT REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M81	YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY.
4227	BPA-RP-REV - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4244	BPA-RP-DIAG - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M78	Missing/incomplete/invalid HCPCS modifier.
4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4254	BPA-RP-REV - AGE RESTRICTION	6	The procedure code is inconsistent with the patient's age.	M50	Missing/incomplete/invalid revenue code(s).
4260	NDC REQUIRED FOR PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4264	NDC NOT ON THE DRUG FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4266	NDC NOT COVERED - PRIMARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4267	NDC NOT COVERED - SECONDARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4268	NDC NOT COVERED - NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4269	NDC NOT COVERED - SECOND NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4270	NDC NOT COVERED - NDC RATED LESS THAN EFFECTIVE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4271	DUPLICATE NDC FOR CLAIM DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4272	NDC NOT COVERED - OBSOLETE OR TERMINATED ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4278	NDC NOT COVERED - NDC NOT EFFECTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4279	NDC NOT COVERED - NDC INACTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4280	NDC NOT COVERED - NDC IN REJECT REGARDLESS ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4281	NDC NOT COVERED - REPACKAGED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4316	BPA-PC -ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4317	BPA-PC-ICD - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4318	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4319	BPA-PC-ICD - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4320	BPA-PC-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4364	BPA-PC-ICD - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4374	BPA-RP-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4376	BPA-RP-ICD - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4400	BPA-RP-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4401	BPA-PC-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4402	BPA-RR-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4403	BPA-RP-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4404	BPA-PC-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4405	BPA-RR-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4406	BPA-RP-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4407	BPA-PC-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4408	BPA-RR-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4409	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4410	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4411	BPA-RR-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4412	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4413	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4414	BPA-RR-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4415	BPA-RP-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4416	BPA-PC-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4417	BPA-RR-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4418	BPA-RP-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4419	BPA-PC-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4420	BPA-RR-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4421	BPA-RP-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4422	BPA-PC-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4423	BPA-RR-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4424	BPA-RP-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4425	BPA-PC-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4426	BPA-RR-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4427	BPA-RP-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4428	BPA-PC-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4429	BPA-RR-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4430	BPA-RP-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4431	BPA-PC-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4432	BPA-RR-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4433	BPA-RP-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4434	BPA-PC-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4435	BPA-RR-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4436	BPA-RP-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4437	BPA-PC-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4438	BPA-RR-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4439	BPA-RP-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4440	BPA-PC-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4441	BPA-RR-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4442	BPA-RP-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4443	BPA-PC-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4444	BPA-RR-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4445	BPA-RR-PROC - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4446	BPA-RP-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4447	BPA-PC-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4448	BPA-RR-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4449	BPA-RP-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4450	BPA-PC-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4451	BPA-RR-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4479	BPA-RP-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4480	BPA-PC-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4481	BPA-RR-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4482	BPA-RP-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4483	BPA-PC-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4484	BPA-RR-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4485	BPA-RP-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4486	BPA-PC-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4487	BPA-RR-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
4519	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4523	BPA-RP-ICD - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4529	BPA-RP-REV - PROV COUNTY RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).
4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4532	BPA-RR-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4535	BPA-RP-ICD - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4540	BPA-PC-PROC - MIN UNIT RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4560	BPA-RP-ICD - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4562	BPA-RP-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4565	BPA-RR-ICD - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4716	BPA-PC-ICD - AGE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4723	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA36	Missing/incomplete/invalid patient name.
4724	BPA-RP-ICD - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4726	BPA-RP-ICD - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4732	BPA-RP-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4747	BPA-PC-ICD - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4748	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4751	BPA-PC-REV - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4762	BPA-PC-ICD - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4765	BPA-RP-ICD - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4767	BPA-RP-ICD - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4801	BPA-PC-PROC - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4802	BPA-PC-DIAG - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4804	BPA-PC-REV - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4806	BPA-PC-ICD - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4873	BPA-PC-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4874	BPA-PC-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4876	BPA-PC-ICD - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4900	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4905	BPA-RP-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4923	BPA-PC-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4940	BPA-RP-ICD - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4941	BPA-RP-ICD - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4942	BPA-RP-ICD - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4944	BPA-PC-ICD - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4950	BPA-PC-ICD - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4951	BPA-PC-ICD - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4952	BPA-PC-ICD - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4960	BPA-RP-NDC - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4961	BPA-RP-PROC - PROV COUNTY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4962	BPA-PC-NDC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4963	BPA-PC-PROC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4964	BPA-PC-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4965	BPA-PC-NDC - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4966	BPA-RR - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4970	BPA-RP-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4971	BPA-RP-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4975	BPA-PC-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4976	BPA-PC-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4981	BPA-RP-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4991	BPA-PC-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP	96	Non-covered charge(s).	N30	Recipient ineligible for this service.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5214	PROCEDURE CODE NOT ALLOWED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5218	SUPPLY CODE CANNOT BE BILLED WITH LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5219	SUPPLY CODE HAS BEEN PAID IN HISTORY, CANNOT BILL A LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N59	Please refer to your provider manual for additional program and provider information.
5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N59	Please refer to your provider manual for additional program and provider information.
5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5285	DME HUMIDIFIER OR CPAP/CPAP CONTRA	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.
5286	DME CPAP OR HUMIDIFIER/CPAP CONTRA	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.
5287	DME CATHETER CONTRA FOR A4221	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5288	DME HUMIDIFIER OR BIPAP/BIPAP CONTRA	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.
5289	DME BIPAP OR HUMIDIFIER/BIPAP CONTRA	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5314	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5315	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5316	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5317	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5318	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5319	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5320	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5321	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5322	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5323	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY, THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY, THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5329	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5334	PALLIATIVE (EMERGENCY) TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5335	PALLIATIVE (EMERGENCY) TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.	107	The related or qualifying claim/service was not identified on this claim.	N59	Please refer to your provider manual for additional program and provider information.
5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5410	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5430	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE AS AN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE AS AN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5436	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5439	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5442	FP- LEVONORGESTREL- CONTRA (J7302-5 YR)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5443	FP- LEVONORGESTREL- CONTRA (Q0090-3 YR)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5480	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5481	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5482	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5483	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5488	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5490	LAB-CHLAMYDIA/GONOR RHEA CONTRA	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5506	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M83	Service is not covered unless the patient is classified as at high risk.
5507	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M83	Service is not covered unless the patient is classified as at high risk.
5508	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5602	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
5606	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5607	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5610	PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5613	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5616	CRITICAL CARE CANNOT BE BILLED ON THE SAME DAY AS PROCEDURE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5633	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5634	THE SAME PHYSICIAN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5635	THE SAME PHYSICIAN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5638	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5639	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5643	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5646	POST-OPERATIVE CARE IS INCLUDED IN THE SURGERY FEE AND CANNOT BE BILLED SEPARAT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5647	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N59	Please refer to your provider manual for additional program and provider information.
5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITIAL CARE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5664	INITIAL OFFICE VISIT CANNOT BE BILLED ANYTIME WITHIN 3 YEARS OF A PRIOR VISIT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5665	PRIOR VISIT CANNOT BE BILLED WITHIN 3 YEARS PRIOR TO AN INITIAL OFFICE VISIT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5666	NEW PATIENT/EXISTING PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5667	EXISTING PATIENT/NEW PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5733	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5751	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5760	ESWL PRICING	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N59	Please refer to your provider manual for additional program and provider information.
5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5791	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5792	PHYSICAL THERAPY APPLIANCES CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
5816	HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5820	LTC VENT CANNOT BE BILLED WITHOUT LTC STAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5821	ADD - ON CODE CANNOT BE PAID WITHOUT PAID PRIMARY CODE	107	The related or qualifying claim/service was not identified on this claim.	N122	ADD-ON CODE CANNOT BE BILLED BY ITSELF.
5822	AVASTIN J9035 NEGATIVE CONTRA	204	This service/equipment/drug is not covered under the patients current benefit plan.	N59	Please refer to your provider manual for additional program and provider information.
5823	PACE NH DEPENDENT ON PACE NON-NH BILLING	168	PAYMENT DENIED AS SERVICE(S) HAVE BEEN CONSIDERED UNDER THE PATIENT'S MEDICAL PLAN. BENEFITS ARE NOT AVAILABLE UNDER THIS DENTAL PLAN	N59	Please refer to your provider manual for additional program and provider information.
5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6041	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6042	PROCEDURE LIMITED TO ONCE EVERY 30 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6043	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6044	EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.	119	Benefit maximum for this time period or occurrence has been reached.	N117	THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME.
6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.	119	Benefit maximum for this time period or occurrence has been reached.	N117	THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6100	DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6101	DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6102	DME PROCEDURE LIMITED TO 1 PER 5 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6104	DME PROCEDURE LIMITED TO 700 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6105	DME CLOSED POUCH TOTAL LIMIT OF 60 PER CAL MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6107	DME PROCEDURE LIMITED TO 40 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6108	DME WC PRESSURE PAD TOTAL LIMIT OF 1 PER CAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6109	PROCEDURE CODE IS LIMITED TO 100 PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6113	DME CODES LIMITED TO THIRTY-ONE UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6114	DME PROCEDURE LIMITED TO 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6115	MEDICAL SUPPLIES LIMIT IS \$1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6116	DME PROCEDURE LIMITED TO 1 PER 4 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6117	DME PROCEDURE LIMITED TO 3 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6118	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6121	DME PROCEDURE LIMITED TO 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6122	LEG BAGS ARE LIMITED TO TWO PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6123	DME PROCEDURE LIMITED TO 8 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6124	DME PROCEDURE LIMITED TO 1 PER 3 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6125	DME PROCEDURE LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6126	DME PROCEDURE LIMITED TO 120 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6128	DME PROCEDURE LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6129	DME PROCEDURE LIMITED TO 4 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6130	DME PROCEDURE LIMITED TO 5 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6131	DME PROCEDURE LIMITED TO 10 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6132	DME PROCEDURE LIMITED TO 12 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6133	DME PROCEDURE LIMITED TO 50 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6134	DME PROCEDURE LIMITED TO 90 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6135	DME PROCEDURE LIMITED TO 100 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6136	DME PROCEDURE LIMITED TO 500 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6137	DME PROCEDURE LIMITED TO 1000 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6138	DME PROCEDURE LIMITED TO 1 PER 2 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6139	DME PROCEDURE LIMITED TO 4 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6140	DME PROCEDURE RENTAL LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6141	DME PROCEDURE RENTAL LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6142	DME PROCEDURE RENTAL LIMITED TO 31 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6143	DME BATTERY CHARGER TOTAL LIMIT OF 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6144	DME BATTERY TOTAL LIMIT OF 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6150	VISION AND HEARING SCREENING ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6154	MAXIMUM UNIT LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6179	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6185	EYE LENS LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6186	EYE FRAME LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6187	EYE EXAM LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6188	EYE FITTING LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6189	EYE EXAM LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6190	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6191	EYE REFRACTION LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6192	EYE REFRACTION LIMIT 1 PER 2 YEARS (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6193	EYE EXAM LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6194	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6195	EYE FRAME LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6196	EYE LENS LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6197	EYE FITTING LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6200	THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6211	DEPO-PROVERA INJECTION LIMITED TO ONE PER EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6212	FP-LEVONORGESTREL-IU LIMIT-1 PER 3 YRS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6230	MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE SAME DATE OF SERV	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
6231	MORE THAN ONE DENTAL ENCOUNTER (D9430)CANNOT BE PAID ON THE SAME DATE OF SERVIC	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
6240	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6241	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6242	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6243	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6244	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6245	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6246	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6247	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6248	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6249	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6260	NUMBER OF HOME HEALTH VISITS EXCEED LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6280	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6281	OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6282	INPATIENT DAYS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6283	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6284	MEPD FISCAL YEAR DOLLAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
6285	HOSPITAL EMERG LIMIT 3 DAYS PER ADMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6290	MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6291	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6292	LAB DRUG SCREENING LIMIT OF 1 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6293	LAB ?DRUG SCREENING LIMIT OF 1 EVERY 7 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6300	THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6301	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6302	MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6303	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6305	ES - VAGINAL DELIVERY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6306	ES - C-SECTION LIMIT LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6307	PRENATAL OFFICE VISIT LIMIT PERINATOLOGIST	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6311	QTY DISPENSED EXCEEDS MAX QTY BASED ON PA	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
6350	DME GESTATIONAL INSULIN LIMIT 4 BOXES PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6351	DME GESTATIONAL INSULIN LIMIT 2 BOXES PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6400	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
6401	OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUI	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6402	SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6403	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6404	PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6405	PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6406	NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6407	THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIP	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6408	PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT	B14	Payment denied because only one visit or consultation per physician per day is covered.	N59	Please refer to your provider manual for additional program and provider information.
6409	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6410	PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6411	INITIAL CRITICAL CARE LIMITED TO ONE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6412	ER AND CRITICAL CARE CODE ONE PER CLAIM.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
6413	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6416	EMG PROCEDURE LIMIT TO 4 PER CAL YR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6418	OB ULTRASOUND YEARLY LIMIT PERINATOLOGISTS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6510	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6511	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6512	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6513	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6514	THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6515	THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6516	THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6517	THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6518	PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6519	PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6520	PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6521	THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6522	THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6523	BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6524	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6525	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6526	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6527	BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6528	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6529	PROCEDURE IS LIMITED TO 260 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6530	PROCEDURE IS LIMITED TO 8 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6531	PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6532	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6533	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6534	PROCEDURE IS LIMITED TO 2016 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6535	PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6536	PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6537	PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6538	YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6539	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6540	PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6541	DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6542	PROCEDURE IS LIMITED TO 4160 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6549	MENTAL HEALTH NON-EMERGENCY TRANSPORTATION LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6610	DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6611	PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6612	PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6613	PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6630	THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6640	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6641	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6642	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6643	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6644	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6645	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6646	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6647	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6650	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THIS CONTRACT YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6651	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6652	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6653	PROCEDURE LIMITED TO 1080 HOURS,PER WAIVER YEAR OCTOBER 1 - SEPTEMBER 30.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6670	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6671	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS RECIP	18	Duplicate claim/service.	N117	THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME.
6673	PROCEDURE IS LIMITED TO ONE (1) EVERY TWO YEARS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6677	PROCEDURE CODE CANNOT BE BILLED MORE THAN SIX(6) TIMES WITH THE SAME MODIFIER.	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
6690	REVENUE CODE 183 IS LIMITED TO 6 DAYS EACH CALENDAR QUARTER.	119	Benefit maximum for this time period or occurrence has been reached.	N43	Bed hold or leave days exceeded.
6691	REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N43	Bed hold or leave days exceeded.
6700	DME PROCEDURE LIMITED TO 1 PER 8 CAL YRS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6701	DME PROCEDURE LIMIT TO 1 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6702	DME PROCEDURE LIMIT TO 1 PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6703	DME PROCEDURE LIMIT TO 15 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6704	DME PROCEDURE LIMIT TO 35 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6705	DME PROCEDURE LIMIT TO 150 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6706	DME PROCEDURE LIMIT TO 180 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6707	DME PROCEDURE LIMIT TO 210 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6708	DME PROCEDURE LIMIT TO 2 PER 3 CALENDAR MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6709	DME PROCEDURE LIMIT TO 3 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6710	DME PROCEDURE LIMIT TO 5 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6711	DME PROCEDURE LIMIT TO 6 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6712	DME PROCEDURE LIMIT TO 2 PER CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6713	DME PROCEDURE LIMIT TO 10 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6714	DME PROCEDURE LIMIT TO 12 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6715	DME PROCEDURE LIMIT TO 2 PER CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6716	DME PROCEDURE LIMIT TO 31 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6717	DME PROCEDURE LIMIT TO 150 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6718	DME PROCEDURE LIMIT TO 31 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6719	DME PROCEDURE LIMITED TO (1) PER 8 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6720	DME PROCEDURE LIMIT TO 1 PER CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

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