

Provider Remittance Advice Codes

April 2015

Explanation of Benefit (EOB), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) may appear on a Provider Remittance Advice (RA) or Provider Electronic Remittance Advice for Paid, Denied or Adjusted claims.

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------|
| 0201 | INVALID PAY-TO PROVIDER NUMBER | 208 | National Provider Identifier - not matched. | N280 | MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER. |
| 0203 | RECIPIENT I.D. NUMBER MISSING | 31 | Claim denied as patient cannot be identified as our insured. | N382 | Missing/incomplete/invalid patient identifier. |
| 0204 | RECIPIENT ID - OLD FORMAT | A1 | Claim/Service denied. | N382 | Missing/incomplete/invalid patient identifier. |
| 0206 | 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. |
| 0208 | PREGNANCY INDICATOR INVALID | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 0210 | BRAND MEDICALLY NECESSARY INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N123 | This is a split service and represents a portion of the units from the originally submitted service. |

| | | | | | |
|------|--------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 0211 | INVALID REFILL INDICATOR VALUE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0212 | 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. |
| 0213 | DATE PRESCRIBED IS MISSING | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N57 | MISSING/INCOMPLETE/INVALID PRESCRIBING DATE. |
| 0214 | DATE PRESCRIBED IS INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N57 | MISSING/INCOMPLETE/INVALID PRESCRIBING DATE. |
| 0215 | 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. |
| 0216 | 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. |
| 0217 | 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). |

| | | | | | |
|------|---------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 0218 | 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). |
| 0219 | 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. |
| 0220 | 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. |
| 0221 | MISSING DAYS SUPPLY | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0222 | ESTIMATED DAYS SUPPLY INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0223 | 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. |
| 0224 | 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. |

| | | | | | |
|------|--------------------------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------|
| 0225 | 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. |
| 0226 | 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. |
| 0227 | THIRD PARTY PAYMENT AMOUNT INVALID | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 0233 | 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. |
| 0234 | 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). |
| 0235 | 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). |
| 0236 | 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). |
| 0239 | 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. |

| | | | | | |
|------|------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------|
| 0240 | 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. |
| 0242 | SECONDARY DIAGNOSIS CODE 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. |
| 0243 | 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. |
| 0244 | THIRD DIAGNOSIS CODE 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. |
| 0246 | FOURTH DIAGNOSIS CODE 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. |
| 0247 | MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0248 | 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. |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------|
| 0249 | 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. |
| 0250 | 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. |
| 0251 | FIRST MODIFIER INVALID FOR DATE OF SERVICE | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 0252 | SECOND MODIFIER INVALID FOR DATE OF SERVICE | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 0253 | THIRD MODIFIER INVALID FOR DATE OF SERVICE | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 0255 | 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). |
| 0256 | 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). |
| 0257 | 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). |
| 0258 | 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. |

| | | | | | |
|------|----------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------------------------------------------------|
| 0260 | 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. |
| 0261 | 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. |
| 0262 | 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. |
| 0263 | 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. |
| 0264 | 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. |
| 0265 | 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. |
| 0266 | 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. |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------|
| 0267 | DUPLICATE TOOTH SURFACES SUBMITTED ON DETAIL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0268 | 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. |
| 0269 | 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. |
| 0270 | 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. |
| 0271 | 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. |
| 0272 | PRIMARY DIAGNOSIS CODE INVALID | 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. |
| 0273 | 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. |

| | | | | | |
|------|---------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------|
| 0274 | 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. |
| 0275 | 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. |
| 0276 | 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. |
| 0277 | 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. |
| 0278 | 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. |
| 0279 | 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. |
| 0280 | 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. |

| | | | | | |
|------|--------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------|
| 0281 | 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. |
| 0282 | 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. |
| 0283 | 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. |
| 0284 | 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. |
| 0285 | 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. |
| 0286 | 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. |
| 0287 | 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. |

| | | | | | |
|------|------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------|
| 0288 | 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. |
| 0289 | 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. |
| 0290 | 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. |
| 0295 | 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). |
| 0296 | 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). |
| 0297 | 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). |
| 0298 | 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). |

| | | | | | |
|------|----------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------|
| 0299 | 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). |
| 0300 | 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). |
| 0301 | 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). |
| 0302 | 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). |
| 0311 | PRIMARY DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0312 | SECOND DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0313 | THIRD DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|-------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 0314 | FOURTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0315 | FIFTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0316 | SIXTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0317 | SEVENTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0318 | EIGHTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0319 | NINTH DIAGNOSIS PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0320 | DIAGNOSIS 10-24 PRESENT ON ADMISSION INDICATOR INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|-------------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------|
| 0339 | 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). |
| 0340 | 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). |
| 0350 | 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). |
| 0355 | FIFTH DIAGNOSIS CODE 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. |
| 0356 | SIXTH DIAGNOSIS CODE 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. |
| 0357 | SEVENTH DIAGNOSIS CODE 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. |
| 0358 | EIGHTH DIAGNOSIS CODE 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. |

| | | | | | |
|------|-----------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------|
| 0359 | NINTH DIAGNOSIS CODE 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. |
| 0360 | ADMITTING DIAGNOSIS MISSING | 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. |
| 0361 | ADMITTING DIAGNOSIS CODE INVALID | 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. |
| 0363 | PRINCIPAL ICD PROCEDURE CODE IS INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0364 | 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. |
| 0365 | 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. |
| 0366 | FIRST 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 | | |

| | | | | | |
|------|-----------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------|
| 0367 | 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). |
| 0368 | 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). |
| 0369 | 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) |
| 0370 | 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). |
| 0371 | 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). |
| 0372 | THIRD 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 | | |
| 0373 | 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). |

| | | | | | |
|------|--------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------|
| 0374 | 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). |
| 0375 | FOURTH 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 | | |
| 0376 | 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). |
| 0377 | 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). |
| 0378 | FIFTH 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 | | |
| 0379 | 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). |
| 0380 | 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). |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------|
| 0381 | 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. |
| 0395 | 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. |
| 0396 | 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. |
| 0397 | 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. |
| 0398 | 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. |
| 0400 | 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. |
| 0411 | 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). |

| | | | | | |
|------|---------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------|
| 0412 | 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). |
| 0413 | 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). |
| 0414 | 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). |
| 0415 | 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). |
| 0416 | 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). |
| 0417 | 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). |
| 0418 | 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). |

| | | | | | |
|------|-------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0433 | 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. |
| 0434 | MEDICARE COINSURANCE AMOUNT INVALID | 2 | Coinsurance Amount | | |
| 0436 | TOTAL MEDICARE ALLOWED AMOUNT INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | M49 | Missing/incomplete/invalid value code(s) or amount(s). |
| 0438 | COPAY AMOUNT INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | M49 | Missing/incomplete/invalid value code(s) or amount(s). |
| 0450 | 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. |
| 0455 | DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using 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. |
| 0456 | 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). |

| | | | | | |
|------|--------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0457 | 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). |
| 0458 | THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT | 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. |
| 0465 | 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). |
| 0466 | 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). |
| 0471 | 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 appropriate | M44 | Missing/incomplete/invalid condition code. |
| 0473 | 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. |
| 0474 | 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). |

| | | | | | |
|------|------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------|
| 0475 | 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). |
| 0500 | DATE PRESCRIBED AFTER BILLING DATE | 110 | BILLING DATE PREDATES SERVICE DATE. | N57 | MISSING/INCOMPLETE/INVALID PRESCRIBING DATE. |
| 0502 | 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. |
| 0503 | DATE DISPENSED AFTER BILLING DATE | 110 | BILLING DATE PREDATES SERVICE DATE. | N304 | MISSING/INCOMPLETE/INVALID DISPENSED DATE. |
| 0505 | NO PAYMENT MADE-TPL IS MORE THAN THE ALLOWED AMOUNT. | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 0507 | 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. |
| 0508 | 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. |
| 0512 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 | The time limit for filing has expired. | M46 | MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE. |
| 0513 | NAME ON CLAIM MUST MATCH NAME ON FILE | 140 | Patient/Insured health identification number and name do not match. | MA36 | Missing/incomplete/invalid patient name. |
| 0514 | DATE RECEIVED FOR PROCESSING- PRIOR TO DATE OF SERV | 110 | BILLING DATE PREDATES SERVICE DATE. | M59 | Missing/incomplete/invalid to date(s) of service. |

| | | | | | |
|------|---------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0519 | ADMIT DATE GREATER THAN FIRST DATE OF SERVICE | 110 | BILLING DATE PREDATES SERVICE DATE. | MA40 | Missing/incomplete/invalid admission date. |
| 0526 | 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. |
| 0527 | 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. |
| 0537 | HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE | 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. |
| 0555 | 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. |
| 0557 | MEPD LATE FILING | 29 | The time limit for filing has expired. | N59 | Please refer to your provider manual for additional program and provider information. |
| 0568 | DISCHARGE DATE IS LESS THAN ADMIT DATE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0570 | 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. |

| | | | | | |
|------|----------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------------------------|
| 0571 | 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). |
| 0573 | 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. |
| 0574 | 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. |
| 0575 | 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. |
| 0589 | 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. |
| 0595 | 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. |
| 0596 | FILE SEPARATE CLAIMS FOR DIFFERENT YEARS | 129 | Payment denied - Prior processing information appears incorrect. | N61 | Rebill services on separate claims. |
| 0602 | 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. |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------|
| 0606 | INVALID OTHER PAYER 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. |
| 0620 | 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. |
| 0621 | 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. |
| 0622 | 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. |
| 0623 | 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. |
| 0624 | 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. |
| 0625 | 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. |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------|
| 0626 | 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. |
| 0627 | 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. |
| 0628 | 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. |
| 0629 | 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. |
| 0630 | 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. |
| 0631 | 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. |
| 0632 | 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. |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------|
| 0633 | 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. |
| 0634 | 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. |
| 0635 | 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. |
| 0636 | 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. |
| 0637 | 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. |
| 0643 | 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. |
| 0644 | OTHER PAYER PAT RESP AMT IS INVALID | 3 | Co-payment Amount | M58 | Missing/incomplete/invalid claim information. Resubmit claim after corrections. |
| 0645 | OTHER PAYER PAT RESP QUALIFIER IS INVALID | 3 | Co-payment Amount | M58 | Missing/incomplete/invalid claim information. Resubmit claim after corrections. |

| | | | | | |
|------|--------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------|
| 0646 | PT RESPONSIBILITY MUST BE GT ZERO | 107 | The related or qualifying claim/service was not identified on this claim. | | |
| 0647 | OTHER PAYER AMOUNT MUST BE GT ZERO | 107 | The related or qualifying claim/service was not identified on this claim. | | |
| 0666 | MO Systematic denial of recycled suspense. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0675 | 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. |
| 0676 | 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. |
| 0677 | 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. |
| 0678 | 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. |
| 0679 | 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. |

| | | | | | |
|------|-------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------|
| 0680 | 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. |
| 0681 | 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. |
| 0682 | ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0683 | ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0684 | 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. |
| 0685 | 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. |
| 0686 | 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. |

| | | | | | |
|------|--------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------|
| 0687 | 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. |
| 0688 | CANNOT ADJUST THIS CLAIM DUE TO PHP TERMINATION. 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 | | |
| 0689 | ADJ - ORIGINAL CLAIM CANNOT BE ADJUSTED - NCCI | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0800 | DETAIL RATE NOT NUMERIC | 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. |
| 0801 | DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT | 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. |
| 0802 | MISSING OR INVALID PRESCRIBER ID QUALIFIER | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0803 | DATED EXCEED SOBRA/QMB ELIGIBILITY | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | N61 | Rebill services on separate claims. |

| | | | | | |
|------|----------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------|
| 0804 | BILLING PROVIDER CANNOT BE PRESCRIBER | 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. |
| 0805 | NONCOVERED CHARGE IS NOT NUMERIC | 96 | Non-covered charge(s). | M79 | Missing/incomplete/invalid charge. |
| 0806 | MEDICARE PAID AMOUNT MISSING OR 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. |
| 0807 | 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. |
| 0808 | 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. |
| 0809 | 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. |
| 0810 | INVALID DEDUCTIBLE AMT - SKILLED NURSING FACILITY | 1 | DEDUCTIBLE AMOUNT | | |
| 0811 | HEADER FROM DATE OF SERVICE > ICN DATE | 110 | BILLING DATE PREDATES SERVICE DATE. | M52 | Missing/incomplete/invalid from date(s) of service. |
| 0812 | ADMIT DATE IS GREATER THAN ICN DATE | 110 | BILLING DATE PREDATES SERVICE DATE. | MA40 | Missing/incomplete/invalid admission date. |

| | | | | | |
|------|--------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------|
| 0813 | 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. |
| 0814 | DETAIL TO DATE OF SERVICE > ICN DATE | 110 | BILLING DATE PREDATES SERVICE DATE. | M59 | Missing/incomplete/invalid to date(s) of service. |
| 0815 | SURGICAL ICD REQUIRES OPERATING PHYSICIAN | 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. |
| 0816 | COINSURANCE DAYS NOT NUMERIC | 2 | Coinsurance Amount | MA34 | Missing/incomplete/invalid number of coinsurance days during the billing period. |
| 0817 | INVALID COINSURANCE DAYS | 2 | Coinsurance Amount | MA34 | Missing/incomplete/invalid number of coinsurance days during the billing period. |
| 0818 | LIFETIME RESERVE DAYS NOT NUMERIC | 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. |
| 0819 | LIFETIME RESERVE DAYS > MAX ALLOWED | 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. |
| 0820 | FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N61 | Rebill services on separate claims. |
| 0821 | NON-COVERED DAYS MISSING OR NOT NUMERIC | 78 | Non-Covered days/Room charge adjustment. | MA33 | Missing/incomplete/invalid noncovered days during the billing period. |

| | | | | | |
|------|----------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------|
| 0822 | SURGICAL REVENUE CODE REQUIRES ICD SURGERY CODE | 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) |
| 0823 | RECIPIENT CHECK DIGIT IS MISSING OR INVALID | 31 | Claim denied as patient cannot be identified as our insured. | N382 | Missing/incomplete/invalid patient identifier. |
| 0824 | UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 0825 | MEDICARE ALLOWED AMOUNT MISSING OR 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. |
| 0826 | 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. |
| 0829 | DAYS SUPPLY > 3 FOR EMERGENCY PHARMACY CLAIM | 154 | Payer deems the information submitted does not support this days supply. | | |
| 0830 | MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N219 | PAYMENT BASED ON PREVIOUS PAYERS ALLOWED AMOUNT. |
| 0831 | MEDICARE HDR PAID AMNT NOT EQUAL SUM OF DTL PAID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N219 | PAYMENT BASED ON PREVIOUS PAYERS ALLOWED AMOUNT. |

| | | | | | |
|------|--------------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------|
| 0832 | OTHER PAYER AMOUNT PAID QUALIFIER INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0833 | CO-INSURANCE AMOUNT DOES NOT BALANCE | 2 | Coinsurance Amount | | |
| 0835 | MEDICARE DATA NOT FOUND - FORMAT ERROR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0836 | MEDICARE PAID, DEDUCTIBLE AMOUNTS INVALID - BOTH CANNOT BE ZERO **OR** MEDICAR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | M49 | Missing/incomplete/invalid value code(s) or amount(s). |
| 0837 | CLAIM DATES OVERLAP PLAN EFFECTIVE DATES | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | | |
| 0838 | COPAY AMOUNT DOES NOT BALANCE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | M49 | Missing/incomplete/invalid value code(s) or amount(s). |
| 0839 | REBILL SERVICES ON SEPARATE CLAIMS | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | N61 | Rebill services on separate claims. |
| 0842 | ES CLAIM REQUIRES DELIVERY | A1 | Claim/Service denied. | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). |
| 0843 | EMERG CLAIMS REQUIRE A CERTIFIED EMERGENCY | A1 | Claim/Service denied. | N54 | Claim information is inconsistent with pre-certified/authorized services. |
| 0844 | HOSPICE CLAIM ONLY ONE LINE ALLOWED PER CLAIM | A1 | Claim/Service denied. | N61 | Rebill services on separate claims. |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------|
| 0900 | 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. |
| 0901 | 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. |
| 0902 | 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. |
| 0903 | 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. |
| 0904 | GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0905 | 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. |
| 0906 | 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). |

| | | | | | |
|------|-------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------|
| 0907 | GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 0908 | GROUP NUMBER NOT FOUND IN VALUE GROUP TABLE | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 0909 | 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. |
| 0910 | BENEFIT PLAN GROUP NOT FOUND | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0911 | INTERNAL PROCESSING ERROR - CONTACT HP | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0912 | INTERNAL ERROR-DOLLAR DISTRIBUTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0913 | 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). |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------|
| 0914 | 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. |
| 0915 | 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. |
| 0916 | 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. |
| 0917 | 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). |
| 0918 | 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. |
| 0919 | 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. |
| 0920 | DRUG THERAPEUTIC CLASS GROUP NOT FOUND | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------------|
| 0921 | 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. |
| 0922 | TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE | 1 | DEDUCTIBLE AMOUNT | | |
| 0923 | RULE OVERLAP IDENTIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 0924 | SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND | 63 | Correction to a prior claim. | M47 | Missing/incomplete/invalid internal or document control number. |
| 0925 | 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. |
| 1019 | MULTIPLE RATES FOR LEVEL OF CARE - RATE CHANGE OVERLAPS SERVICE DATES; SPLIT BI | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1020 | ATTENDING PHYSICIAN ID NOT ON FILE | 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. |
| 1021 | FIRST OTHER (OPERATING) PROVIDER ID NOT ON FILE | 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. |
| 1024 | BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV | 242 | Services not provided by network/primary care providers. | N257 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER. |

| | | | | | |
|------|---------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------|
| 1026 | PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE | 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. |
| 1032 | PROVIDER TYPE - CLAIM INPUT CONFLICT | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. | | |
| 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 | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N256 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER NAME. |

| | | | | | |
|------|------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------|
| 1070 | ATTENDING PROVIDER ID NOT ON FILE - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1071 | OPERATING PROVIDER ID NOT ON FILE - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1072 | ATTENDING PROVIDER ID NOT ON FILE - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1073 | OPERATING PROVIDER ID NOT ON FILE - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1074 | PRESCRIBING PROVIDER NOT ON FILE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 1081 | REFERRING PROV NOT ENROLLED SVC LOC HDR-PHYS-DNTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1082 | REFERRING PROV NOT ENROLLED SVC LOC DTL-PHYS-DNTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1083 | REFERRING PROV NOT ENROLLED AT SVC LOC - HDR - UB | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1084 | ATTENDING PROV - NOT ENROLLED AT SVC LOC - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1085 | OPERATING PROV - NOT ENROLLED AT SVC LOC - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1086 | REFERRING PROV - NOT ENROLLED AT SVC LOC - DTL-UB | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1087 | ATTENDING PROV - NOT ENROLLED AT SVC LOC - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1088 | OPERATING PROV - NOT ENROLLED AT SVC LOC - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1089 | PRESCRIBING PROV - NOT ENROLLED AT SVC LOC | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1091 | REFER PROV STATUS NOT VALID FOR DOS HDR-PHYS-DNTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1092 | REFER PROV STATUS NOT VALID FOR DOS DTL-PHYS-DNTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1093 | REFERRING PROV STATUS NOT VALID FOR DOS - HDR - UB | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1094 | ATTENDING PROV - STATUS NOT VALID FOR DOS - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1095 | OPERATING PROV - STATUS NOT VALID FOR DOS - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1096 | REFERRING PROV - STATUS NOT VALID FOR DOS - DTL-UB | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|----------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------|
| 1097 | ATTENDING PROV - STATUS NOT VALID FOR DOS - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1098 | OPERATING PROV - STATUS NOT VALID FOR DOS - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1099 | PRESCRIBING PROV - 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 | | |
| 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. |
| 1803 | BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. | N55 | Procedures for billing with group/referring/performing providers were not followed. |
| 1804 | VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. | N55 | Procedures for billing with group/referring/performing providers were not followed. |
| 1805 | BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. | N95 | This provider type/provider specialty may not bill this service. |
| 1806 | EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS UNDER | 6 | The procedure code is inconsistent with the patient's age. | | |

| | | | | | |
|------|---------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------|
| 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. |
| 1808 | REFERRING PROVIDER IS MISSING OR NOT ON FILE | 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. |
| 1809 | REFERRING PROVIDER-NO SCREENING SPECIALTY FOR DOS | 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. |
| 1810 | PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. | N95 | This provider type/provider specialty may not bill this service. |
| 1812 | RECIPIENT / ADMIT AGE GREATER THAN 21 | 6 | The procedure code is inconsistent with the patient's age. | | |
| 1813 | PROVIDER SUSPENDED FOR OUTSTANDING CREDIT BALANCE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N280 | MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER. |
| 1814 | BILLING PROVIDER NOT VALID FOR DATES OF SERVICE | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of 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. |

| | | | | | |
|------|--------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------|
| 1816 | MATERNITY CARE MUST BE PERFORMED BY DISTRICT PROV | 242 | Services not provided by network/primary care providers. | N257 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER 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. |
| 1818 | WAIVER PROVIDER MISMATCH | 242 | Services not provided by network/primary care providers. | N256 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER NAME. |
| 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 | 243 | Services not authorized by network/primary care providers. | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. |
| 1821 | MEDICAL LOCKIN - RECIPIENT LOCKED IN TO OTHER PROVIDER | 243 | Services not authorized by network/primary care providers. | N257 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER. |
| 1822 | MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | | |
| 1823 | WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | | |
| 1824 | LTC ASSIGNMENT DATES OVERLAP CLAIM DATES | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | | |
| 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. |

| | | | | | |
|------|-----------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------|
| 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. |
| 1929 | NPI REQUIRED HEALTHCARE=Y REFERRING PROV | 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. |
| 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. |
| 1935 | DTL NPI REQUIRED HEALTHCARE=Y REFERRING PROV | 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. |
| 1936 | INVALID BILLING PROVIDER SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N257 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER. |
| 1937 | INVALID PREFORMING PROVIDER SPECIFIED | 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. |

| | | | | | |
|------|-------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------|
| 1938 | INVALID REFERRING PROVIDER SPECIFIED | 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. |
| 1939 | INVALID FACILITY PROVIDER SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N278 | MISSING/INCOMPLETE/INVALID OTHER PAYER SERVICE FACILITY PROVIDER IDENTIFIER. |
| 1940 | INVALID RENDERING PROVIDER SPECIFIED | 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. |
| 1941 | INVALID OTHER PROVIDER SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N270 | MISSING/INCOMPLETE/INVALID OTHER PROVIDER PRIMARY IDENTIFIER. |
| 1942 | INVALID DTL OTHER PROVIDER SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N270 | MISSING/INCOMPLETE/INVALID OTHER PROVIDER PRIMARY IDENTIFIER. |
| 1943 | INVALID DTL PREFORMING PROVIDER SPECIFIED | 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. |
| 1944 | INVALID DTL REFERRING PROVIDER SPECIFIED | 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. |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 1945 | MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N259 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER SECONDARY IDENTIFIER. |
| 1946 | MULT SAK PROV LOCS FOR PERFORMING PROV SPEC | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N291 | MISSING/INCOMPLETE/INVALID RENDERING PROVIDER SECONDARY IDENTIFIER. |
| 1949 | MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER | 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. |
| 1952 | MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER | 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. |
| 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. |

| | | | | | |
|------|--------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------|
| 1963 | ATTENDING PROVIDER - NPI REQUIRED - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1964 | OPERATING PROVIDER- NPI REQUIRED - HDR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1965 | ATTENDING PROVIDER- NPI REQUIRED - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1966 | OPERATING PROVIDER- NPI REQUIRED - DTL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 1970 | INVALID ATTENDING PROVIDER OVERRIDE SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------|
| 1971 | INVALID DTL ATTENDING PROVIDER OVERRIDE SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1972 | INVALID OTHER PROVIDER 1 OVERRIDE SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 1973 | INVALID DTL OTHER PROVIDER 1 OVERRIDE SPECIFIED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 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. |

| | | | | | |
|------|-----------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------|
| 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. |
| 1995 | MMIS FACILITY PROVIDER ID NOT ENROLLED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N270 | MISSING/INCOMPLETE/INVALID OTHER PROVIDER PRIMARY IDENTIFIER. |
| 1996 | THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM. | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |

| | | | | | |
|------|-----------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------|
| 1999 | PROVIDER ID IS INVALID, IS NOT ON FILE OR NAME/NUMBER DISAGREE. | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 2001 | RECIPIENT IS NOT ON ELIGIBILITY FILE | 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. |
| 2002 | RECIPIENT NOT ELIGIBLE FOR HEADER DATE OF SERVICE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N30 | Recipient ineligible for this service. |
| 2003 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN | 26 | Expenses incurred prior to coverage. | N30 | Recipient ineligible for this service. |
| 2009 | RECIPIENT INELIGIBLE ON DATE OF SERVICE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | 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. |
| 2046 | RECIPIENT PATIENT STATUS INVALID FOR CLAIM | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2047 | ADMIT REASON/SOURCE OF ADMISSION MISSING/INVALID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|--------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------------------------------|
| 2048 | RECIPIENT DISCHARGE RSN MISSING/INVALID(SUSPEND) | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2050 | ADMIT DATE MUST EQUAL HDR FIRST SVC DATE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2054 | UNABLE TO DETERMINE FUND CODE - DETAIL | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2055 | UNABLE TO DETERMINE AID CAT OR COUNTY | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2056 | RECIPIENT ELIGIBILITY - CHIP OVERLAP | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2057 | RECIPIENT PARTIALLY ELIGIBLE - HEADER | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | N61 | Rebill services on separate claims. |
| 2077 | RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | N61 | Rebill services on separate claims. |
| 2500 | RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT) | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | | |

| | | | | | |
|------|--------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------------------------------------------------|
| 2501 | RECIPIENT COVERED BY MEDICARE A (WITH ATTACHMENT) | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | | |
| 2502 | RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT) | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | | |
| 2503 | RECIPIENT COVERED BY MEDICARE B (WITH ATTACHMENT) | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | | |
| 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/ATTACHMNT) | 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. |
| 2550 | RECIPIENT ENROLLED IN MEDICARE ADVANTAGE PLAN | 109 | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | | |
| 2590 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------|
| 2591 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 2603 | RECIPIENT LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER | 242 | Services not provided by network/primary care providers. | | |
| 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 | 239 | Claim spans eligible and ineligible periods of coverage. Rebill separate claims. | N61 | Rebill services on separate claims. |
| 2805 | DOS PRIOR TO DOB | 14 | The date of birth follows the date of service. | | |
| 2806 | PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |

| | | | | | |
|------|-------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------|
| 3000 | UNITS EXCEED AUTHORIZED UNITS ON PA MASTER FILE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N54 | Claim information is inconsistent with pre-certified/authorized services. |
| 3001 | PA NOT FOUND ON DATABASE | 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. |
| 3002 | NDC REQUIRES PA | 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. |
| 3003 | PROCEDURE REQUIRES PRIOR AUTHORIZATION | 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. |
| 3006 | PRIOR AUTH UNITS/AMOUNTS USED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N54 | Claim information is inconsistent with pre-certified/authorized services. |
| 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. |
| 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). |
| 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. |
| 3101 | ONLINE PA DENIED BY HID, NDC REQUIRES PA | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 3102 | ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 3103 | ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |

| | | | | | |
|------|---------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------|
| 3105 | DAW 1 - BRAND WITH GENERIC EQUIVALENT REQUIRES OVERRIDE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 3301 | BILL EMERGENCY PROCEDURE/REVENUE TOGETHER | 199 | Revenue code and Procedure code do not match. | | |
| 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). |
| 3303 | MEDICARE PAID AMOUNT EQUAL 100% | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 3304 | NON-COVERED SVC FOR RECIPIENT < 6 MONTHS OLD | 6 | The procedure code is inconsistent with the patient's age. | | |
| 3306 | HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 3310 | DISPENSING FEE NOT LOCATED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|--------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------|
| 3311 | REFILL NUMBER EXCEEDS MAXIMUM ALLOWED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 3312 | DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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 RECIPIENT | 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). |
| 3317 | CLAIM QUANTITY EXCEEDS NDC MAX UNITS | 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. |

| | | | | | |
|------|----------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------|
| 3320 | SERVICE INCLUDED IN FACILITY FEE | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | | |
| 3321 | NO PRICING SEGMENT ON FILE - CONTACT MYERS AND STAUFFER AT 1-800-591-1183. | 133 | The disposition of this claim/service is pending further review. | | |
| 3322 | DAW CODE NOT ALLOWED WITH NDC SUMMITTED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N123 | This is a split service and represents a portion of the units from the originally submitted service. |
| 3323 | PROCEDURE RESTRICTION - MODIFIER REQUIRED | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 3324 | PROCEDURE RESTRICTION - NOT ALLOWED | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 3325 | QUANTITY MUST BE DIVISIBLE BY PACKAGE SIZE | 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. |
| 3326 | PHARMACY MAINTENANCE SUPPLY REQUIRED FOR DRUG | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N123 | This is a split service and represents a portion of the units from the originally submitted service. |
| 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. |
| 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. |
| 3360 | DIAGNOSIS 10-24 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 | | |
| 3599 | MANUAL PRICING REQUIRED | 101 | Predetermination: anticipated payment upon completion of services or claim adjudication. | | |
| 3800 | SERVICE COVERAGE HAS NOT BEEN DETERMINED | 133 | The disposition of this claim/service is pending further review. | | |
| 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). |
| 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). |
| 4023 | BPA-RP-NDC - GENDER RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4025 | BPA-RP-NDC - AGE RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4027 | DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE | 146 | Diagnosis was invalid for the date(s) of service reported. | | |
| 4028 | BPA-RP-DIAG - GENDER RESTRICTION | 10 | The diagnosis is inconsistent with the patient's gender. | | |
| 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. |
| 4030 | BPA-RP-DIAG - AGE RESTRICTION | 9 | The diagnosis is inconsistent with the patient's age. | | |
| 4031 | BPA-PC-DIAG - GENDER RESTRICTION | 10 | The diagnosis is inconsistent with the patient's gender. | | |
| 4032 | PROCEDURE CODE IS MISSING/NOT ON FILE | 96 | Non-covered charge(s). | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). |
| 4034 | BPA-RP-PROC - AGE RESTRICTION | 6 | The procedure code is inconsistent with the patient's age. | | |

| | | | | | |
|------|------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------|
| 4035 | BPA-RP-PROC - GENDER RESTRICTION | 7 | The procedure code is inconsistent with the patient's gender. | | |
| 4036 | BPA-RP-PROC - PLACE OF SERVICE RESTRICTION | 5 | The procedure code/bill type is inconsistent with the place of service. | | |
| 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. |
| 4040 | PRIMARY DIAGNOSIS 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 | MA63 | Missing/incomplete/invalid principal diagnosis. |
| 4041 | SECONDARY DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4042 | THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE | 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. |
| 4043 | FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE | 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. |
| 4044 | BPA-RR-DIAG - NO RULE FOR ASSOC AGE | 9 | The diagnosis is inconsistent with the patient's age. | | |
| 4045 | BPA-RR - 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 | | |

| | | | | | |
|------|---------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------------------|
| 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. |
| 4047 | FIFTH DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4048 | SIXTH DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4049 | SEVENTH DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4050 | EIGHTH DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4051 | NINTH DIAGNOSIS 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 | M76 | Missing/incomplete/invalid diagnosis or condition. |
| 4052 | ADMITTING DIAGNOSIS 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 | MA65 | Missing/incomplete/invalid admitting diagnosis. |

| | | | | | |
|------|-----------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------|
| 4053 | PRINCIPAL 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 | | |
| 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. |
| 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. |
| 4068 | BPA-RR - NO RULE CURR BILL PROV CONTRACT | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 4070 | BPA-RR-PROC - MODIFIER RESTRICTION | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 4071 | BPA-RR-PROC - TOOTH NUMBER RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4072 | BPA-RR-DRG - NO RULE FOR ADMIT OR HDR DIAGNOSIS | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|-----------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------|
| 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). |
| 4076 | BPA-RP-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 | | |
| 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. |
| 4094 | BPA-PC-REV - PROV COUNTY RESTRICTION | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 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. |
| 4127 | CANNOT PRIORITIZE RECIPIENT'S PROGRAMS | 133 | The disposition of this claim/service is pending further review. | | |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 4128 | ICD PROCEDURE 7-24 NOT ON FILE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4130 | PAYER HIERARCHY NOT FOUND | A1 | Claim/Service denied. | M56 | Missing/incomplete/invalid payer identifier. |
| 4131 | NO BENEFIT PLANS ASSOCIATED TO PAYER | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 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). |
| 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). |
| 4164 | INACTIVE DRUG | 96 | Non-covered charge(s). | | |
| 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). |
| 4200 | CLAIM PRICED AT ZERO | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |
| 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. |

| | | | | | |
|------|-----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------|
| 4215 | BPA-RP-PROC - TOOTH NUMBER RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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). |
| 4231 | BPA-PC-NDC - MAX UNIT RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|-------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|------------------------------------------------------------------|
| 4240 | THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 4245 | FOURTH MODIFIER INVALID FOR DATE OF SERVICE | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 4246 | ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 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. |
| 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). |

| | | | | | |
|------|-----------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 4256 | BPA-RP-PROC - MODIFIER RESTRICTION | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 4257 | BPA-PC-PROC - MODIFIER RESTRICTION | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 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). |
| 4261 | INVALID UNIT OF MEASURE VALUE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4262 | NDC QUANTITY UNITS IS NOT NUMERIC | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4263 | NDC QUANTITY UNITS IS ZERO | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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). |
| 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). |
| 4274 | INVALID PRESCRIPTION QUALIFIER CODE, MUST EQUAL XZ | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4275 | DRUG UNIT PRICE IS NOT NUMERIC | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4276 | DRUG UNIT PRICE IS ZERO | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4277 | PROCEDURE REQUIRES NDC | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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). |
| 4282 | PROCEDURE MUST BE SUBMITTED ON PAPER WITH APPROPRIATE NDC, DRUG DESCRIPTION, AN | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4283 | MANUAL PRICE NON-CLASSIFIED PROCEDURE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 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. |

| | | | | | |
|------|------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------|
| 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. |
| 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. |
| 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. |

| | | | | | |
|------|---------------------------------------------------------|----|-------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 4500 | BPA-RR-NDC - ALGI RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4501 | BPA-RR-NDC - NO RULE FOR DISP AS WRITTEN IND | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4502 | BPA-RP-PROC - EPSDT REFERRAL RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|-----------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 4503 | BPA-PC-PROC - EPSDT REFERRAL RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4504 | BPA-RP-NDC - ALGI RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4505 | BPA-RR-PROC - NO RULE FOR URBAN/RURAL IND | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4506 | BPA-PC-DIAG - PERF 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 | | |
| 4508 | BPA-PC-PROC - PERF 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 | | |
| 4509 | BPA-PC-REV - PERF 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 | | |
| 4511 | BPA-RP-DIAG - PERF 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 | | |

| | | | | | |
|------|--------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------|
| 4514 | BPA-RP-PROC - PERF 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 | | |
| 4515 | BPA-RP-REV - PERF 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 | | |
| 4516 | BPA-PC-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 | | |
| 4517 | BPA-PC-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 | | |
| 4518 | BPA-PC-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 | | |
| 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). |
| 4526 | BPA-PC-PROC - PROV COUNTY RESTRICTION | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 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. |
| 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. |
| 4563 | BPA-RR - NO RULE CURR PERF PROV CONTRACT | B7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. | | |
| 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. |
| 4711 | BPA-PC-DIAG - AGE RESTRICTION | 9 | The diagnosis is inconsistent with the patient's age. | | |
| 4713 | BPA-PC-NDC - AGE RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 4714 | BPA-PC-PROC - AGE RESTRICTION | 6 | The procedure code is inconsistent with the patient's age. | | |
| 4715 | BPA-PC-REV - AGE RESTRICTION | 6 | The procedure code is inconsistent with the patient's age. | | |
| 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. |
| 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. |
| 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. |
| 4755 | BPA-PC-PROC - 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 | | |
| 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). |
| 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. |
| 4766 | BPA-RP-ICD - AGE RESTRICTION | 9 | The diagnosis is inconsistent with the patient's age. | | |

| | | | | | |
|------|---------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------|
| 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. |
| 4775 | BPA-PC-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 | | |
| 4776 | BPA-PC-DIAG - 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 | | |
| 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. |
| 4803 | BPA-PC-NDC - NO CONTRACT | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 4831 | BPA-RR - NO REIMB RULE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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). |
| 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). |
| 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. |
| 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). |
| 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. |

| | | | | | |
|------|-------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|------------------------------------------------|
| 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). |
| 4980 | BPA-RP-PROC - BENEFIT PLAN RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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). |
| 4990 | BPA-PC-PROC - BENEFIT PLAN RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------|
| 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. |
| 4994 | BPA-RP-NDC - SPECIFIC THERA CLASS RESTRICTION | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 5000 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | Duplicate claim/service. | | |
| 5001 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | Duplicate claim/service. | | |
| 5002 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | Duplicate claim/service. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|--------------------------|--|--|
| 5005 | DENTAL DUPLICATE EXACT | 18 | Duplicate claim/service. | | |
| 5006 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | Duplicate claim/service. | | |
| 5010 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5011 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5012 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5013 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5014 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5015 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5016 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|-------------------------------------------------------------------------------------|-----|-------------------------------------------------------------------|
| 5017 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5018 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | Duplicate claim/service. | | |
| 5020 | SUSPECT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 | Duplicate claim/service. | | |
| 5021 | EXACT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 | Duplicate claim/service. | | |
| 5022 | DUPLICATE RX NUMBER FOR SAME DATE OF SERVICE. | 18 | Duplicate claim/service. | | |
| 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 THES AME 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. |
| 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. |
| 5216 | COMBINATION VACCINES/SINGLE COMPONENT CONTRA | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------|
| 5217 | SINGLE COMPONENT/COMBINATION VACCINES CONTRA | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 5234 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |
| 5235 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 5237 | ANESTHESIA NOT PAYABLE WITH OTHER ANESTHESIA ON SAME DATE OF SERVICE | A1 | Claim/Service denied. | N20 | Service not payable with other service rendered on the same date. |
| 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. |
| 5260 | BATTERIES MAY NOT BE PURCHASED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 5261 | BATTERIES MAY NOT BE PURCHASED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 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. |
| 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. |
| 5291 | REPLACEMENT/REPAIR INCLUDED IN WARRANTY | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | N130 | Consult plan benefit documents for information about restrictions for this service. |
| 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. |
| 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. |
| 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. |
| 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. |
| 5340 | ORAL EVALUATION < 3 YRS (D0145) CONTRA | 18 | Duplicate claim/service. | | |
| 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. |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------|
| 5352 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | N384 | Records indicate that the referenced body part/tooth has been removed in a previous procedure. |
| 5353 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | 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 SERVIC | 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 SERVIC | 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. |
| 5404 | EPSDT VISIT HAS BEEN PAID FOR THIS RECIPIENT FOR THE SAME DATE OF SERVICE. | 18 | Duplicate claim/service. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 5410 | MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC | 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 SERVIC | 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. |
| 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. |
| 5416 | VISUAL FIELDS/TONOMOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | | |
| 5417 | VISUAL FIELDS/TONOMOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | | |
| 5430 | AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN 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. |
| 5434 | PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD. | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 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. |
| 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. |
| 5455 | HOSPICE ONE PER DAY CONTRA | A1 | Claim/Service denied. | N20 | Service not payable with other service rendered on the same date. |
| 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. |
| 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. |
| 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/GONORRHEA 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. |
| 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 | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | M83 | Service is not covered unless the patient is classified as at high risk. |
| 5507 | SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY | 97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. | 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. |
| 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. |

| | | | | | |
|------|---------------------------------------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 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. |
| 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. |
| 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. |
| 5634 | THE SAME PHYSICAIN 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 PHYSICAIN 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. |
| 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. |
| 5652 | ONLY ONE INITIAL NICU PROCEDURE MAY BE BILLED PER HOSPITAL STAY. | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 5653 | SURGERY/CASTING & STRAPPING CONTRA | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 5654 | CASTING & STRAPPING/SURGERY CONTRA | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 5655 | MULTIPLE SURGERY CONTRAS | 18 | Duplicate claim/service. | | |
| 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. |
| 5658 | A CARDIOLOGIST OR A RADIOLOGIST CANNOT BILL THIS PROCEDURE CODE ON THE SAME DAY | 18 | Duplicate claim/service. | | |
| 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. |

| | | | | | |
|------|------------------------------------------------------------------------------|----|---------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 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. |
| 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. |
| 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. | N524 | Based on policy this payment constitutes payment in full. |
| 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. |
| 5770 | INDEPENDENT RURAL HEALTH CLINICS CANNOT BE PAID FOR MORE THAN ONE SERVICE PER D | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 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. |
| 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. |
| 5811 | HEARING AND VISION SCREENING REQUIRE EP MODIFIER. | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 5812 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 5813 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 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. |
| 5825 | FP OUTPT LARC REQUIRES INPT | 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. |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 5900 | NCCI-MUE - UNITS OF SERVICE EXCEED MUE. RECIPIENT CANNOT BE BILLED. | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5910 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON THIS CLAIM. RECIPIENT CANNOT | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 5911 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5912 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5920 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON THIS CLAIM. RECIPIENT CANNOT | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5921 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------------------------------------------|
| 5922 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5930 | NCCI- SVC IS A DUPE OF A PREVIOUSLY DENIED NCCI SVC. RECIPIENT CANNOT BE BILLED | A1 | Claim/Service denied. | N702 | Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services. |
| 5940 | NCCI -SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON THIS CLAIM. RECIPIENT CANNOT | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 5941 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |

| | | | | | |
|------|---------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 5942 | NCCI - SERVICE NOT PAYABLE WITH ANOTHER SERVICE ON ANOTHER CLAIM. RECIPIENT CAN | 236 | This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. | | |
| 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. |
| 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. |
| 6040 | PERIAPICAL XRAYS - LIMIT 5 PER CAL YEAR | 18 | Duplicate claim/service. | | |
| 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. |
| 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. |
| 6054 | ORAL EVALUATION < 3 YRS (D0145) | 18 | Duplicate claim/service. | | |
| 6056 | FLOURIDE VARNISH < 3YRS - LIMIT 3 PER CAL YEAR | 18 | Duplicate claim/service. | | |
| 6057 | FLOURIDE VARNISH < 3YRS - LIMIT 6 TOTAL | 18 | Duplicate claim/service. | | |
| 6058 | FLOURIDE VARNISH > 3YRS - LIMIT 1 PER CAL YEAR | 18 | Duplicate claim/service. | | |
| 6060 | DENTAL BITEWING X-RAYS - LIMIT 1 PER 6 CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6061 | DENTAL PROCEDURE LIMIT - 1 PER DATE OF SERVICE | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 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. |
| 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. |
| 6127 | DME PROCEDURE LIMITED TO 400 PER CALENDAR MONTH | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 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. |
| 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. |
| 6145 | DME NON-INSULIN PROC LIMIT OF 2 PER 3 CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6146 | DME NON-INSULIN PROC LIMIT OF 1 PER 3 CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6147 | DME INSULIN PROC LIMIT OF 4 PER CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6148 | DME INSULIN PROC LIMIT OF 3 PER CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |

| | | | | | |
|------|----------------------------------------------------|-----|-------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 6149 | DME INSULIN PROC LIMIT OF 2 PER CAL MO | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 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. |
| 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. |
| 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. |
| 6210 | RADIOLOGY - LEVONORGESTREL IU LIMIT - 1 PER 5 YRS | 18 | Duplicate claim/service. | | |
| 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. |
| 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. |
| 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. |
| 6270 | HOSPICE ONE (1) UNIT PER DAY | 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. |
| 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. |
| 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. |
| 6304 | OBSTETRICAL CARE LIMIT FOR SPECIALTY 921 | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 6308 | TOBACCO CESSATION COUNSELING LIMIT 4 PER 12 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. |
| 6309 | TOBACCO CESSATION COUNSELING LIMIT 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. |
| 6310 | THE QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED FOR THE DRUG CODE P | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 6312 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6313 | MONTHLY SCRIPT LIMIT EXCEEDED - BRANDED DRUG | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6314 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6315 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |

| | | | | | |
|------|---------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 6316 | MONTHLY BRAND SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6317 | MONTHLY BRAND SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6318 | MONTHLY BRAND SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6319 | MONTHLY TOTAL SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6320 | MONTHLY MAXIMUM SCRIPT LIMIT EXCEEDED | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6330 | RECIPIENT HAS RESERVE MEDICINE THAT EXCEEDS LIMIT | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 6331 | PHARMACY STABLE THERAPY REQUIREMENT NOT MET | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 6332 | PHARMACY STABLE THERAPY REQUIREMENT NOT MET | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 6543 | PSYCHOLOGY/REHAB - PSYCHOLOGY DX TESTING | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6544 | PSYCHOLOGY/REHAB - NEUROPSYCHOLOGY DX TESTING | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6546 | PSYCHOLOGY/REHAB - PPSYCHOLOGY LIMIT 52 A YEAR | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6547 | PSYCHOLOGY/REHAB - INDIVIDUAL THERAPY 1 PER WEEK | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 6548 | PSYCHOLOGY/REHAB - GROUP THERAPY 1 PER WEEK | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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. |
| 6600 | RADIOLOGY & CARDIOLOGY - PROCEDURE REQUIRES PA | 197 | Precertification/authorization/notification absent. | | |
| 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. |
| 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. |
| 6654 | LAHWV - LIMITED \$1000 PER WAIVER 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. |
| 6655 | LAHWV-TRANSPORTATION LIMITED \$1000 PER WAIVER 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. |
| 6656 | PERSONAL CARE BACHELORS DEGREE LIMIT | 119 | Benefit maximum for this time period or occurrence has been reached. | N640 | Exceeds number/frequency approved/allowed within time period. |
| 6657 | PERSONAL CARE MASTERS DEGREE LIMIT | 119 | Benefit maximum for this time period or occurrence has been reached. | N640 | Exceeds number/frequency approved/allowed within time period. |
| 6658 | SPEECH/HEARING THERAPY LIMIT | 119 | Benefit maximum for this time period or occurrence has been reached. | N640 | Exceeds number/frequency approved/allowed within time period. |
| 6661 | PACE GLOBAL FEE LIMITED TO ONE PER MONTH | B5 | Payment adjusted because coverage/program guidelines were not met or were exceeded. | | |
| 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 RECIPIENT | 18 | Duplicate claim/service. | N117 | THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME. |
| 6672 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT | 18 | Duplicate claim/service. | | |
| 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. |
| 6674 | CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL. | 18 | Duplicate claim/service. | | |
| 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. |

| | | | | | |
|------|------------------------------------------------|-----|----------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 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. |
| 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. |
| 6721 | DME REPAIRS LIMITED \$1000 PER DAY | 119 | Benefit maximum for this time period or occurrence has been reached. | N640 | Exceeds number/frequency approved/allowed within time period. |
| 6722 | DME POWER TIRES LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6723 | DME BACK CUSHIONS LIMIT 1 PER 2 CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6724 | DME SEAT CUSHIONS LIMIT 1 PER 2 CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6725 | DME FOOTREST LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6726 | DME ARMREST LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6727 | DME HEADREST LIMIT 1 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |

| | | | | | |
|------|------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|
| 6728 | DME SAFETY VEST LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6729 | DME MANUAL TIRES LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6730 | DME MANUAL CASTERS LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6731 | DME POWER CASTERS LIMIT 2 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 6732 | DME GENERAL CUSHION LIMIT 1 PER CALENDAR YEAR | 119 | Benefit maximum for this time period or occurrence has been reached. | | |
| 7000 | CLAIM FAILED A PRODUR ALERT | 133 | The disposition of this claim/service is pending further review. | | |
| 7001 | INFORMATIONAL PRODUR ALERT | 175 | PAYMENT DENIED BECAUSE THE PRESCRIPTION IS INCOMPLETE | | |
| 7002 | CLAIM DENIED FOR PRODUR REASONS | 6 | The procedure code is inconsistent with the patient's age. | | |
| 7003 | PRODUR ALERT REQUIRES PA FOR OVERRIDE | 6 | The procedure code is inconsistent with the patient's age. | | |
| 7004 | NON-OVERRIDEABLE PRODUR ALERT | 6 | The procedure code is inconsistent with the patient's age. | | |
| 7503 | CONFLICT CODE ON RESPONSE CLAIM DOES NOT MATCH | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 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. |

| | | | | | |
|------|-----------------------------------------------------|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------|
| 926 | PROCEDURE MODIFIER RESTRICTION ERROR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |
| 9999 | PROCESSED PER MEDICAID POLICY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------|------------------|------------------------------|------------------|-------------------------|
| 8000 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR. | 63 | Correction to a prior claim. | | |
| 8001 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER. | 63 | Correction to a prior claim. | | |
| 8002 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE. | 63 | Correction to a prior claim. | | |
| 8003 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR. | 63 | Correction to a prior claim. | | |
| 8004 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-------------------------------------------------------------------------------|------------------|------------------------------|------------------|-------------------------|
| 8005 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN. | 63 | Correction to a prior claim. | | |
| 8006 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR. | 63 | Correction to a prior claim. | | |
| 8007 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR. | 63 | Correction to a prior claim. | | |
| 8008 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR | 63 | Correction to a prior claim. | | |
| 8019 | PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR. | 63 | Correction to a prior claim. | | |
| 8020 | SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT. | 63 | Correction to a prior claim. | | |
| 8021 | SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER. | 63 | Correction to a prior claim. | | |
| 8022 | SURS INITIATED A FULL OFFSET DUE TO WRONG RECIPIENT NUMBER. | 63 | Correction to a prior claim. | | |
| 8023 | SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-----------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8024 | SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE. | 63 | Correction to a prior claim. | | |
| 8025 | SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT. | 63 | Correction to a prior claim. | | |
| 8026 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE. | 63 | Correction to a prior claim. | | |
| 8027 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE. | 63 | Correction to a prior claim. | | |
| 8028 | SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE. | 63 | Correction to a prior claim. | | |
| 8030 | PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8031 | PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8032 | PROVIDER REQUESTED OFFSET DUE MEDICARE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8033 | PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8034 | PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8035 | PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8036 | PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8037 | PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8038 | PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8039 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8040 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8041 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8042 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8043 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8045 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8046 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8047 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8048 | SAVE FOR FUTURE USE. | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | | |
| 8049 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8050 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-------------------------|
| 8051 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8052 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8053 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8054 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8055 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8056 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8057 | SAVE FOR FUTURE USE. | 104 | Managed care withholding. | | |
| 8059 | PROVIDER SENT A FULL REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR. | 63 | Correction to a prior claim. | | |
| 8060 | PROVIDER SENT REFUND DUE TO BILLING ERROR. | 63 | Correction to a prior claim. | | |
| 8061 | PROVIDER SENT REFUND DUE TO | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| | CLAIMS PROCESSING ERROR. | | | | |
| 8062 | PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT. | 63 | Correction to a prior claim. | | |
| 8063 | PROVIDER SENT REFUND DUE TO EFT DEPOSIT ERROR. | 63 | Correction to a prior claim. | | |
| 8064 | PROVIDER SENT REFUND DUE TO MEDICARE. | 63 | Correction to a prior claim. | | |
| 8065 | PROVIDER SENT REFUND DUE TO OFMQ REVIEW. | 63 | Correction to a prior claim. | | |
| 8066 | PROVIDER SENT REFUND DUE TO OTHER INSURANCE. | 63 | Correction to a prior claim. | | |
| 8067 | PROVIDER SENT REFUND DUE TO SURS REVIEW. | 63 | Correction to a prior claim. | | |
| 8068 | PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW. | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | | |
| 8069 | PROVIDER SENT REFUND DUE TO LEGAL SETTLEMENT. | 63 | Correction to a prior claim. | | |
| 8070 | PROVIDER SENT REFUND DUE TO MEDICAID FRAUD. | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-----------------------------------------------------------------|------------------|----------------------------------|------------------|------------------------------|
| 8071 | PROVIDER SENT REFUND PAYMENT DUE TO MEDICAID FRAUD. | 123 | Payer refund due to overpayment. | | |
| 8072 | PROVIDER SENT REFUND DUE TO AUTO LIABILITY. | 123 | Payer refund due to overpayment. | | |
| 8073 | PROVIDER SENT REFUND DUE TO WORKERS COMP. | 123 | Payer refund due to overpayment. | | |
| 8074 | PROVIDER SENT REFUND FOR CLAIM NOT IN HISTORY. | 123 | Payer refund due to overpayment. | | |
| 8075 | PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR. | 123 | Payer refund due to overpayment. | | |
| 8076 | PROVIDER SENT REFUND DUE TO PATIENT LIABILITY PROCES | 123 | Payer refund due to overpayment. | MA67 | Correction to a prior claim. |
| 8079 | CONVERTED CLAIM WAS GENERATED FOR A FULL REFUND | 123 | Payer refund due to overpayment. | | |
| 8080 | CONVERTED CLAIM WAS GENERATED FOR A PARTIAL REFUND | 123 | Payer refund due to overpayment. | | |
| 8081 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8082 | NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR. | 63 | Correction to a prior claim. | | |
| 8083 | NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 8084 | NON-CLAIM SPECIFIC REFUND DUE TO SURS. | 63 | Correction to a prior claim. | | |
| 8085 | NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR. | 63 | Correction to a prior claim. | | |
| 8086 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8087 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8088 | SAVE FOR FUTURE USE. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N4 | Missing/incomplete/invalid prior insurance carrier EOB. |
| 8090 | AGENCY REQUESTED REFUND DUE TO ACCOUNTS RECEIVABLE | 100 | PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE PARTY/EMPLOYER. | | |
| 8091 | AGENCY REQUESTED REFUND DUE TO AUDIT DIVISION REVIEW | 123 | Payer refund due to overpayment. | M104 | Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service. |
| 8092 | AGENCY REQUESTED REFUND DUE TO BILLING ERROR | 123 | Payer refund due to overpayment. | N20 | Service not payable with other service rendered on the same date. |
| 8093 | AGENCY REQUESTED REFUND DUE TO CLAIMS PROCESSING ERROR | 123 | Payer refund due to overpayment. | | |
| 8094 | AGENCY REQUESTED REFUND DUE TO WRONG PROVIDER PAID/EFT ERROR | 123 | Payer refund due to overpayment. | M1 | X-ray not taken within the past 12 months or near enough to the start of treatment. |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|------------------|------------------------------|
| 8095 | AGENCY REQUESTED REFUND DUE TO MEDICARE | 123 | Payer refund due to overpayment. | | |
| 8096 | AGENCY REQUESTED REFUND DUE TO OFMQ | 123 | Payer refund due to overpayment. | | |
| 8097 | AGENCY REQUESTED REFUND DUE TO OTHER INSURANCE | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | MA67 | Correction to a prior claim. |
| 8098 | AGENCY REQUESTED REFUND DUE TO SURS REVIEW | 123 | Payer refund due to overpayment. | | |
| 8099 | AGENCY REQUESTED REFUND DUE TO LEGAL SETTLEMENT | 63 | Correction to a prior claim. | | |
| 8100 | AGENCY REQUESTED REFUND DUE TO MEDICAID FRAUD. | 63 | Correction to a prior claim. | | |
| 8101 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8102 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8103 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8104 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8105 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8106 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8107 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8110 | AGENCY INITIATED OFFSET DUE AUDIT DIVISION REVIEW | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8111 | AGENCY INITIATED OFFSET DUE TO CALL CENTER | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8112 | AGENCY INITIATED OFFSET DUE TO CLAIMS RESOLUTION | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8113 | AGENCY INITIATED OFFSET DUE TO COST SETTLEMENT ADJUSTMENT | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8114 | AGENCY INITIATED OFFSET DUE TO CUSTOMER SERVICE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8115 | AGENCY INITIATED OFFSET DUE TO SERVICES AFTER DEATH OF RECIPIENT | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8116 | AGENCY INITIATED OFFSET DUE TO DHS/CHILD WELFARE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8117 | AGENCY INITIATED OFFSET DUE TO DHS/DCYS | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8118 | AGENCY INITIATED OFFSET DUE TO DHS/DDSD | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8119 | AGENCY INITIATED OFFSET DUE TO DISPROPORTIONATE SHARE ADJUS | 63 | Correction to a prior claim. | | |
| 8120 | AGENCY INITIATED OFFSET DUE TO DRUG REBATE. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8121 | AGENCY INITIATED OFFSET DUE TO FINANCIAL MANAGEMENT DIVISION REVIEW | 63 | Correction to a prior claim. | | |
| 8122 | AGENCY INITIATED OFFSET DUE TO FQHC | 63 | Correction to a prior claim. | | |
| 8123 | AGENCY INITIATED OFFSET DUE TO JUVENILE JUSTICE. | 63 | Correction to a prior claim. | | |
| 8124 | AGENCY INITIATED OFFSET DUE TO KEYING ERROR | 63 | Correction to a prior claim. | | |
| 8125 | AGENCY INITIATED OFFSET DUE TO LEGAL SETTLEMENT. | 63 | Correction to a prior claim. | | |
| 8126 | AGENCY INITIATED OFFSET DUE TO MEDICAID FRAUD. | 63 | Correction to a prior claim. | | |
| 8127 | AGENCY INITIATED OFFSET DUE TO MEDICAL REVIEW. | 63 | Correction to a prior claim. | | |
| 8128 | AGENCY INITIATED OFFSET DUE TO MEDICARE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8129 | AGENCY INITIATED OFFSET DUE TO OFMQ REVIEW | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8130 | AGENCY INITIATED OFFSET DUE TO PHARMACY REVIEW | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-----------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8131 | AGENCY INITIATED OFFSET DUE TO PROCESSING ERROR | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8132 | AGENCY INITIATED OFFSET DUE TO SURS REVIEW | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8133 | AGENCY INITIATED OFFSET DUE TO WRONG PROVIDER PAID | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8134 | AGENCY INITIATED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8135 | EDS INITIATED OFFSET DUE TO PROCESSING ERROR | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8136 | EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8137 | AGENCY INITIATED PARTIAL CLAIM OFFSET DUE TO OFMQ REVIEW | 63 | Correction to a prior claim. | | |
| 8138 | AGENCY INITIATED OFFSET DUE TO PRESCRIBING PROVIDER EXCLUDED | 63 | Correction to a prior claim. | | |
| 8139 | AGENCY INITIATED OFFSET OF FFS CLAIM FOR RECIPIENT ENROLLED IN MANAGED CARE | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-------------------------|
| 8140 | AGENCY INITIATED OFFSET OF OUT-PATIENT CLAIM DUE TO PAID IN-PATIENT CLAIM | 63 | Correction to a prior claim. | | |
| 8141 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8142 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8143 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8144 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8145 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8146 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8147 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8148 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8149 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8150 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO CALL CENTER | 123 | Payer refund due to overpayment. | | |
| 8151 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO CLAIMS RESOLUTION | 123 | Payer refund due to overpayment. | | |
| 8152 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO DHS/CHILD WELFARE | 123 | Payer refund due to overpayment. | | |
| 8153 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO DHS/DDSD | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8154 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO DISPROPORTIONATE SHARE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8155 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO FINANCIAL MANAGEMENT REVIEW | 123 | Payer refund due to overpayment. | | |
| 8156 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO FQHC | 123 | Payer refund due to overpayment. | | |
| 8157 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO KEYING ERROR | 123 | Payer refund due to overpayment. | | |
| 8158 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO MEDICAL REVIEW | 123 | Payer refund due to overpayment. | | |
| 8159 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO MEDICAL AUTHORIZATION | 63 | Correction to a prior claim. | | |
| 8160 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO MEDICARE | 63 | Correction to a prior claim. | | |
| 8161 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO OTHER INSURANCE | 63 | Correction to a prior claim. | | |
| 8162 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|----------------------------------------------------------------------|------------------|------------------------------|------------------|-------------------------|
| 8163 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR | 63 | Correction to a prior claim. | | |
| 8164 | AGENCY INITIATED ADDITIONAL PAYMENT DUE TO RATE CHANGE | 63 | Correction to a prior claim. | | |
| 8165 | AGENCY INITIATED ADDTNL PYMNT DUE TO MISC OR UNSPEC ERROR | 63 | Correction to a prior claim. | | |
| 8166 | EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR. | 63 | Correction to a prior claim. | | |
| 8167 | EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR. | 63 | Correction to a prior claim. | | |
| 8168 | AGENCY INITIATED ADJUSTMENT DUE TO RATE CHANGE | 63 | Correction to a prior claim. | | |
| 8179 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8180 | MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE. | 63 | Correction to a prior claim. | | |
| 8181 | MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE | 63 | Correction to a prior claim. | | |
| 8182 | MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE. | 63 | Correction to a prior claim. | | |
| 8183 | MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE. | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|----------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8184 | MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE | 63 | Correction to a prior claim. | | |
| 8185 | MASS ADJUSTMENT - RETROACTIVE RATE CHANGE. | 63 | Correction to a prior claim. | | |
| 8186 | MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE). | 63 | Correction to a prior claim. | | |
| 8187 | MASS ADJUSTMENT - OTHER REQUEST | 63 | Correction to a prior claim. | | |
| 8188 | MASS ADJUSTMENT - VOID TRANSACTIONS | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8189 | MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8190 | MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8191 | MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8199 | MASS ADJUSTMENT - VOID TRANSACTIONS IDENTIFIED BY EXTERNAL ENTITY | 216 | Based on the findings of a review organization. | | |
| 8200 | CORRECTION TO A PRIOR CLAIM | 63 | Correction to a prior claim. | | |
| 8201 | DUPLICATE PAYMENT | 63 | Correction to a prior claim. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------|
| 8202 | CLAIM BILLED IN ERROR | 63 | Correction to a prior claim. | | |
| 8203 | BILLED UNDER WRONG RECIPIENT | 63 | Correction to a prior claim. | | |
| 8204 | PRIMARY INSURANCE PAYMENT RECEIVED | 63 | Correction to a prior claim. | | |
| 8205 | PROVIDER TO REBILL | 63 | Correction to a prior claim. | | |
| 8206 | DUE TO MEDICARE PRIMARY | 63 | Correction to a prior claim. | | |
| 8207 | RECOUPMENT OTHER | 63 | Correction to a prior claim. | | |
| 8208 | NCCI REDETERMINATION - HISTORY VOID | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | MA91 | This determination is the result of the appeal you filed. |
| 8209 | NCCI ADMINISTRATIVE REVIEW - HISTORY VOID | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | MA91 | This determination is the result of the appeal you filed. |
| 8210 | WORKER'S COMP - PROVIDER | 19 | Claim denied because this is a work-related injury/illness and thus the liability of the Workers Compensation Carrier. | M1 | X-ray not taken within the past 12 months or near enough to the start of treatment. |
| 8211 | WORKER'S COMP - RECIPIENT | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8212 | PROBATE'S ESTATE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-------------------------|
| 8213 | INCOME PENSION TRUST RECOVERIES | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8214 | VICTIM'S RESTITUTION | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8215 | ABSENT PARENTS | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8216 | TPL ERROR | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8217 | DUE TO MISCELLANEOUS OR UNSPECIFIED REASON | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8220 | FULL REFUND | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 8221 | PARTIAL REFUND | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 8222 | SAVE FOR FUTURE USE | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 8223 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8224 | SAVE FOR FUTURE USE. | 63 | Correction to a prior claim. | | |
| 8225 | CAPITATION - DEATH OF RECIPIENT | 123 | Payer refund due to overpayment. | | |
| 8226 | CAPITATION - RECIPIENT INCARCERATED | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-----------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8227 | CAPITATION - EPSDT CLAIM | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8228 | CAPITATION - RECIPIENT ENROLLED IN ERROR | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8229 | CAPITATION - FAMILY PLANNING | 63 | Correction to a prior claim. | | |
| 8230 | CAPITATION - INCORRECT RATE CATEGORY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8231 | CAPITATION - DEMOGRAPHIC CHANGE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8232 | CAPITATION - OTHER | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8233 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8234 | SAVE FOR FUTURE USE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8235 | AGENCY INITIATED OFFSET DUE TO THIRD PARTY COVERAGE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8239 | ADJUSTMENT GENERATED DUE TO LTC AUDIT FINDING | 216 | Based on the findings of a review organization. | | |
| 8240 | ADJUSTMENT GENERATED DUE TO SURS REVIEW | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8241 | ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8242 | ADJUSTMENT GENERATED DUE TO RATE CHANGE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8243 | ADJUSTMENT GENERATED DUE TO RECIPIENT DATE OF DEATH | A2 | Contractual adjustment. | | |
| 8244 | PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8245 | POINT OF SALE | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8246 | POINT OF SALE REVERSAL | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8251 | HP INITIATED VOID DUE TO CHANGE IN PROVIDER ID OR SERVICE LOCATION INFORMATION. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8299 | ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS | 63 | Correction to a prior claim. | | |
| 8300 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED | 123 | Payer refund due to overpayment. | | |
| 8301 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXC | 123 | Payer refund due to overpayment. | | |
| 8302 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT | 123 | Payer refund due to overpayment. | | |
| 8303 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENT | 123 | Payer refund due to overpayment. | | |
| 8304 | PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE. | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-------------------------|
| 8305 | PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE. | 123 | Payer refund due to overpayment. | | |
| 8306 | CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMO | 123 | Payer refund due to overpayment. | | |
| 8307 | PAYOUT EXCLUDED FROM CHECKWRITE. | 123 | Payer refund due to overpayment. | | |
| 8308 | PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8309 | PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8310 | PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8311 | PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8312 | PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|----------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-------------------------|
| 8313 | PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8314 | PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8315 | PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8316 | PAYOUT DUE TO MANAGED CARE - OTHER | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8317 | PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8318 | PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8319 | PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR | 123 | Payer refund due to overpayment. | | |
| 8320 | PAYOUT DUE TO PATIENT LIABILITY ERROR | 123 | Payer refund due to overpayment. | | |
| 8321 | PAYOUT DUE TO PATIENT SPENDDOWN ERROR | 45 | Charge exceeds fee schedule/maximum allowable or | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| | | | contracted/legislated fee arrangement. | | |
| 8322 | PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8323 | PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8324 | PAYOUT DUE TO OTHER PROGRAM. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8325 | PAYOUT DUE TO GAS SURCHARGE. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8326 | PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8327 | PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT. | 52 | The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. | | |
| 8328 | PAYOUT DUE TO DHS/DDSD AUDIT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8329 | PAYOUT PROCESSED FROM STATE ONLY FUNDS | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8330 | PAYOUT DUE TO ELIGIBILITY NOT ON FILE. | 30 | Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. | | |
| 8331 | PAYOUT DUE TO CLAIM TOO OLD TO PROCESS | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8332 | PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON. | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8336 | RETROACTIVE INTEREST PAYMENT | 85 | Interest amount. | | |
| 8399 | THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. | B13 | Previously paid. Payment for this claim/service may have been provided in a previous payment. | | |
| 8400 | ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED . THE AMOUNT WILL BE DEDUCTED FROM YO | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8401 | DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8402 | DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WIL | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8403 | DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8404 | DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8405 | DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8406 | DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE A | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8407 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8408 | DECREASE TO ORIGINAL LIEN AMOUNT. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8409 | INCREASE TO ORIGINAL LIEN AMOUNT | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8410 | SAVE FOR FUTURE USE | 85 | Interest amount. | | |
| 8411 | SAVE FOR FUTURE USE | 29 | The time limit for filing has expired. | | |
| 8412 | SAVE FOR FUTURE USE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8413 | SAVE FOR FUTURE USE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8414 | SAVE FOR FUTURE USE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8415 | SAVE FOR FUTURE USE . | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8419 | SAVE FOR FUTURE USE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8420 | AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8421 | AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTAB | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8422 | AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8423 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8424 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8425 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8426 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUS | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8427 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE.. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8428 | AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|----------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8429 | AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8430 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAIM | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8431 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS. | 85 | Interest amount. | | |
| 8432 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8433 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8434 | AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. T | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8435 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR. | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8436 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR. | 123 | Payer refund due to overpayment. | | |
| 8437 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW. | 123 | Payer refund due to overpayment. | | |
| 8438 | AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE | 123 | Payer refund due to overpayment. | | |
| 8439 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY. | 123 | Payer refund due to overpayment. | | |
| 8440 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8441 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8442 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8443 | SAVE FOR FUTURE USE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8444 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8445 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8446 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |
| 8447 | SAVE FOR FUTURE USE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8448 | SAVE FOR FUTURE USE. | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8449 | SAVE FOR FUTURE USE. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8450 | DUE TO A TRANSFER OF ACCOUNT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8451 | DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN A | 123 | Payer refund due to overpayment. | | |
| 8452 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8453 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR | 123 | Payer refund due to overpayment. | | |
| 8454 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR | 123 | Payer refund due to overpayment. | | |
| 8455 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORREC | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8456 | A CASH RECEIPT WAS APPLIED TO AND DECREASED THIS ACCOUNTS RECEIVABLE. | 123 | Payer refund due to overpayment. | | |
| 8457 | AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE | 123 | Payer refund due to overpayment. | | |
| 8458 | A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE. | 123 | Payer refund due to overpayment. | | |
| 8459 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8460 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW | 123 | Payer refund due to overpayment. | | |
| 8461 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8462 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW. | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|----------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8463 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8464 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW. | 123 | Payer refund due to overpayment. | | |
| 8465 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8466 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION | 123 | Payer refund due to overpayment. | | |
| 8467 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8468 | THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF. | 123 | Payer refund due to overpayment. | | |
| 8469 | THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET | 123 | Payer refund due to overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8480 | AGENCY INITIATED OFFSET DUE TO CLAIMCHECK INCIDENTAL TO PRIMARY PROCEDURE | 63 | Correction to a prior claim. | | |
| 8481 | AGENCY INITIATED OFFSET DUE TO CLAIMCHECK MUTUALLY EXCLUSIVE | 63 | Correction to a prior claim. | | |
| 8482 | AGENCY INITIATED OFFSET DUE TO CLAIMCHECK PRE-OP/POST-OP | 63 | Correction to a prior claim. | | |
| 8483 | AGENCY INITIATED OFFSET DUE TO CLAIMCHECK MEDICAL/EVALUATION VISIT | 63 | Correction to a prior claim. | | |
| 8484 | AGENCY INITIATED OFFSET DUE TO CLAIMCHECK NEW VISIT FREQUENCY | 63 | Correction to a prior claim. | | |
| 8500 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8501 | PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8502 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 8510 | CYCLE ACTIVITY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 8511 | DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. | 123 | Payer refund due to overpayment. | | |
| 8512 | DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED. | 123 | Payer refund due to overpayment. | | |
| 8513 | INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |
| 8514 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER. | 123 | Payer refund due to overpayment. | | |
| 8515 | THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION. | A1 | Claim/Service denied. | | |
| 8517 | THIS CLAIM ADJUSTMENT DUE TO A PROVIDER SUBMITTED REQUEST | 63 | Correction to a prior claim. | | |
| 8550 | THIS SERVICE IS NOT COVERED BY MEDICAID | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 8551 | THIS DRUG IS NOT AVAILABLE AS AN INJECTABLE | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8552 | THIS DRUG IS CURRENTLY ON THE ALABAMA MEDICAID PHYSICIAN DRUG LIST (APPENDIX H) | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8553 | THIS SERVICE REQUIRES THE USE OF A MODIFIER TO INDICATE ANATOMICAL SITE, DISTIN | 4 | The procedure code is inconsistent with the modifier used or a required modifier is missing. | | |
| 8554 | NCCI REDETERMINATION - APPROVED | 59 | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) | MA91 | This determination is the result of the appeal you filed. |
| 8555 | NCCI REDETERMINATION - DENIED - NO APPEAL | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | MA44 | No appeal rights. Adjudicative decision based on law. |
| 8556 | NCCI REDETERMINATION - DENIED | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | MA46 | The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation. |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 8557 | NCCI ADMINISTRATIVE REVIEW - APPROVED | 59 | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) | MA91 | This determination is the result of the appeal you filed. |
| 8558 | NCCI ADMINISTRATIVE REVIEW - DENIED | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | MA91 | This determination is the result of the appeal you filed. |
| 8560 | PAPER CLAIM AND OPERATIVE NOTE REQUIRED FOR PAYMENT DECISION. PLEASE RESUBMIT. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | N29 | MISSING DOCUMENTATION/ORDERS/NOTES/SUMMARY/REPORT/CHART. |
| 8987 | CLAIM ADJUSTMENT PAID BASED ON RECIPIENT ELIGIBILITY IN EFFECT AT THE TIME THE | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | M17 | Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. |
| 8988 | THE CLAIM IMAGE FOR THIS LEGACY CLAIM WAS RECREATED AFTER THE INTERCHANGE IMPL | 193 | ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME. | | |
| 8989 | AGENCY INITIATED OFFSET DUE TO MEDICARE | 88 | Adjustment amount represents collection against receivable created in prior overpayment. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------|
| 8990 | THIS CLAIM ELECTRONICALLY CREATED TO REPROCESS A DENIED PAPER CLAIM. THE CLAIM | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8991 | SYSTEM ERROR - DETAIL MEDICARE AMOUNTS. A SYSTEM ERROR RESULTED IN THE DELETI | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8992 | CLAIM MODIFIED POST-PROCESSING. DETAIL DATES MODIFIED TO REFLECT SERVICE PERIO | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8993 | CLAIM MODIFIED POST-PROCESSING. PERFORMING PROVIDER RESTORED TO SUBMITTED VALU | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8994 | CLAIM MODIFIED POST-PROCESSING. RECIPIENT ID AND CHECK DIGIT RESTORED TO SUBMI | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 8995 | CLAIM MODIFIED POST-PROCESSING. BILLING PROVIDER OVERRIDDEN TO FORCE CLAIM TO | 125 | Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. | MA67 | Correction to a prior claim. |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|--------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------|
| 8997 | CLAIM MODIFIED POST-PROCESSING. THE BILLED AMOUNT WAS CHANGED TO ZERO ON THE E | 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. |
| 8998 | CLAIM BEING REVIEWED | 133 | The disposition of this claim/service is pending further review. | | |
| 9001 | REIMBURSEMENT REDUCED BY THE RECIPIENT'S CO-PAYMENT AMOUNT. | 3 | Co-payment Amount | | |
| 9003 | NO PAYMENT MADE-TPL IS MORE THAN THE ALLOWED AMOUNT. | 30 | Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. | | |
| 9011 | CLAIM TREATED AS AN ADJUSTMENT. NO MEDICAID ID ON THE CLAIM. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9012 | CLAIM TREATED AS AN ADJUSTMENT. CROSSOVER CLAIM WITH NO MEDICARE PROVIDER NUMB | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9013 | CLAIM TREATED AS AN ADJUSTMENT. HEADER KEY SECTION OF CLAIM IS MISSING. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 9014 | CLAIM TREATED AS AN ADJUSTMENT. CLAIM LACKS ORIGINAL ICN. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9015 | CLAIM TREATED AS AN ADJUSTMENT. BENEFICIARY NOT FOUND ON T_RE_BASE. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9016 | CLAIM TREATED AS AN ADJUSTMENT. BILLING PROVIDER NOT FOUND ON T_PR_PROV. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9017 | CLAIM TREATED AS AN ADJUSTMENT. ORIGINAL ICN NOT FOUND ON T_HIST_DIRECTORY. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9018 | CLAIM TREATED AS AN ADJUSTMENT. CLAIM HAS ALREADY BEEN ADJUSTED. | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9019 | CLAIM TREATED AS AN ADJUSTMENT. CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PR | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------|
| 9400 | THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION R | 62 | Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. | N45 | Payment based on authorized amount. |
| 9500 | COVERED DAYS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE ALLOWED | 16 | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate | | |
| 9501 | PRICING ADJUSTMENT - MEDICARE IP PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9502 | PRICING ADJUSTMENT - MEDICARE PART B HEADER PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9503 | PRICING ADJUSTMENT - MEDICARE HEADER PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9504 | PRICING ADJUSTMENT - MEDICARE HEADER COINSURANCE + DEDUCTIBLE PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9505 | PRICING ADJUSTMENT - MEDICARE LONG TERM CARE PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9506 | PRICING ADJUSTMENT - MEDICARE DETAIL COINSURANCE + DEDUCTIBLE PRICING APPLIED | 92 | Claim Paid in full. | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|------------------|-------------------------|
| 9507 | PRICING ADJUSTMENT - MEDICARE PART B DETAIL 1 PRICING APPLIED | 92 | Claim Paid in full. | | |
| 9508 | PRICING ADJUSTMENT - MEDICARE PART B DETAIL 2 PRICING APPLIED | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 9800 | CUTBACK - CLAIM PROCESSED AS AN ENCOUNTER. | 92 | Claim Paid in full. | | |
| 9907 | TPL AMOUNT APPLIED | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 9908 | PRICING ADJUSTMENT - PHARMACY PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9910 | PHARMACY DISPENSING FEE APPLIED | 91 | Dispensing fee adjustment. | | |
| 9911 | PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9916 | PRICING ADJUSTMENT - UCC RATE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9917 | PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9918 | PRICING ADJUSTMENT - MAX FEE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|-----------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|
| | | | contracted/legislated fee arrangement. | | |
| 9919 | PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9921 | PRICING ADJUSTMENT - PA PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9922 | PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION. | 142 | Claim adjusted by the monthly Medicaid patient liability amount. | | |
| 9926 | CLAIM HAS CUTBACK AMOUNT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9930 | PRICING ADJUSTMENT - ENCOUNTER RATE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9935 | PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9936 | PRICING ADJUSTMENT - TPL PAYER PRICING APPLIED | 23 | Payment adjusted because charges have been paid by another payer. | | |
| 9990 | CLAIM DENIED. CORRECT AND RESUBMIT. | A1 | Claim/Service denied. | N59 | Please refer to your provider manual for additional program and provider information. |
| 9991 | REFUND AMOUNT LESS THAN ADJUSTED AMOUNT | 45 | Charge exceeds fee schedule/maximum allowable or | | |

| <i>EOB CODE</i> | <i>EOB DESCRIPTION</i> | <i>CARC CODE</i> | <i>CARC DESCRIPTION</i> | <i>RARC CODE</i> | <i>RARC DESCRIPTION</i> |
|-----------------|---------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------|
| | | | contracted/legislated fee arrangement. | | |
| 9992 | REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9995 | ADJUSTMENT DETAIL MANUALLY DENIED | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | | |
| 9996 | PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION. | 142 | Claim adjusted by the monthly Medicaid patient liability amount. | | |
| 9997 | PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES C | 142 | Claim adjusted by the monthly Medicaid patient liability amount. | | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | 45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. | N524 | Based on policy this payment constitutes payment in full. |