| EOB | DESCRIPTION |
|---|---|
| 1 | PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR I NVALID. |
| 2 | THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE. |
| 3 | PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, |
| 4 | MEDICARE PAID DATE IS MISSING OR INVALID. |
| 5 | EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM ,ER VIS,CONSULT,OV)/MEMBER/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1OF |
| 6 | THE DISCHARGE DATE IS MISSING OR INVALID. |
| 7 | TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES. |
| 8 | CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE WHICH |
| 9 | CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIM WITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION. |
| 10 | CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT. |
| 11 | NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN |
| 12 | ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVIC E CHANGED TO ONE. |
| 13 | DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE. |
| 14 | CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID. |
| 15 | CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS |
| 16 | CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES. |
| 17 | LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH. |
| 18 | CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID. |
| 19 | CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID. |
| 20 | MEDICARE DOCUMENTATION NOT ATTACHED. |
| 21 | CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH. |
| 22 | COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS. |
| 23 | CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT. |
| 24 | THE DETAIL BILLED AMOUNT IS MISSING OR INVALID. |
| 25 | CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE. |
| 26 | CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT |
| 27 | CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM. |
| 28 | CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT. |
| 29 | CLAIM REQUIRES DOCUMENTATIION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC PROCEDURE CODE AND CRITERIA SET FOR REVIEW. |
| 30 | CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING. |
| 31 | CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT. |
| 32 | CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE. |
| 33 | NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES |
| 34 | DENIED BY MEDICARE. |
| 35 | DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE |
| 36 | CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM. |

| EOB | DESCRIPTION |
|---|---|
| 37 | MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE |
| 38 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE. |
| 39 | THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE. |
| 40 | CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING. |
| 41 | DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, MEMBER. |
| 42 | CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB. |
| 43 | CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID. |
| 44 | CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID. |
| 45 | TYPE OF BILL INVALID FOR PROVIDER TYPE. |
| 46 | CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE. |
| 47 | PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE |
| 48 | CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MAN UAL AN |
| 49 | CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED |
| 50 | CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT |
| 51 | PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL. |
| 52 | ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS. |
| 53 | CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE. |
| 54 | CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM |
| 55 | CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED. |
| 56 | CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY |
| 57 | INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY. |
| 58 | CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 59 | CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID. |
| 60 | CLAIM DENIED. LOCATION CODE INVALID. |
| 61 | PAID IN FULL BY MEDICAID. |
| 62 | CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID. |
| 63 | CLAIM DENIED. AN 8-DIGIT LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FORM LOCATOR #11. |
| 64 | THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN. |
| 65 | DESTINATION CODE IS MISSING/INVALID. |
| 66 | PRO STICKER/INDICATOR MISSING OR INVALID |
| 67 | FAMILY PLANNING INDICATOR INVALID. |
| 68 | AM/PM PICK-UP INDICATOR MISSING OR INVALID. |
| 69 | TIME OF CALL IN MISSING/INVALID. |
| 70 | TIME OF PICK UP IS MISSING OR INVALID. |
| 71 | DESTINATION CODE MISSING/INVALID. |
| 72 | PICK-UP LOCATION CODE MISSING OR INVALID. |

| EOB | DESCRIPTION |
|---|---|
| 73 | REFERRED TO 'OTHER' CODE INVALID. |
| 74 | ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT. |
| 75 | CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAGE |
| 76 | OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID. |
| 77 | CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING |
| 78 | CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID. |
| 79 | CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES). |
| 80 | PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE. |
| 81 | CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID. |
| 82 | CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID. |
| 83 | CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID |
| 84 | CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID. |
| 85 | CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER |
| 86 | PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLL MENT A |
| 87 | CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT. |
| 88 | CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID. |
| 89 | DETAIL CHARGE MISSING OR INVALID. |
| 90 | CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID. |
| 91 | CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR |
| 92 | THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT. |
| 93 | THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES. |
| 94 | PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVIC |
| 95 | CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM |
| 96 | MEMBER'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE. |
| 97 | DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE. |
| 98 | MEMBER MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM. |
| 99 | PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF MEMBER SIGNATURE BUT PRI |
| 100 | DETAIL FROM DATE OF SERVICE MISSING OR INVALID. |
| 101 | DETAIL TO DATE OF SERVICE MISSING OR INVALID. |
| 102 | CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. |
| 103 | MISSING OR ALTERED MEMBER SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE. |
| 105 | CLAIM DENIED. CLAIM SUBMITTED FOR HEARING AID AND HEARING AID PARTS SHALL REFL |
| 106 | INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES. |
| 107 | INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT |
| 108 | CONSENT FORM IS INCOMPLETE |
| 109 | INCORRECT STERLIZATION CONSENT FORM USED. |

| EOB | DESCRIPTION |
|---|---|
| 110 | CLAIM SUSPENDED FOR REVIEW. |
| 111 | ADJUSTMENT REQUEST IN PROCESS |
| 112 | CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILING |
| 113 | CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE. |
| 114 | REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PR |
| 115 | PAYMENT APPLIED TO RECEIVABLE. |
| 116 | DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL. |
| 117 | CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM. |
| 118 | OUR RECORDS INDICATE PAID IN FULL BY MEDICARE. |
| 119 | NOT COVERED UNDER THE PROGRAM EXCEPT UNDER EPSDT. |
| 120 | LAB PROCESSING CHARGE INCLUDED IN FLAT FEE. |
| 121 | THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY MEMBER |
| 122 | THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDI CAID WITH A COPY OF THE MEDICARE EOMB. |
| 123 | CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY. PLEASE REFER T O THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL. |
| 124 | CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR MEMBERS AGE 22 THROUGH 64. |
| 125 | THE TOOTH NUMBER IS MISSING OR INVALID. |
| 126 | PROCEDURE CODE(S) IS INVALID FOR OTHER THAN ANTERIOR TOOTH NUMBERS. |
| 127 | CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID. |
| 128 | THE TOOTH NUMBER IS MISSING OR INVALID. |
| 129 | KYCONV-DESCRIPTION NOT FOUND |
| 130 | CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXC EEDED. |
| 131 | CLAIM/DETAIL DENIED. CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY. |
| 132 | SERVICE NOT AUTHORIZED. |
| 133 | THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION (PA). CURRENTLY, EDITING |
| 134 | MAP-34 FORM INCOMPLETE. |
| 135 | CLAIM/DETAIL DENIED. FULL MOUTH DEBRIDEMENT IS ONLY PAYABLE FOR |
| 136 | PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE. |
| 137 | CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHARGES. |
| 138 | CLAIM DENIED. LOCK-IN MEMBER. |
| 139 | CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PER MEMBER. |
| 140 | CLAIM PENDING REVIEW. MEMBER IS A POTENTIAL LOCK-IN MEMBER. |
| 141 | PROCEDURE CODE MODIFIER MISSING/INVALID. |
| 142 | CLAIM DENIED. PREGNACY INDICATOR INVALID FOR MEMBERENT AGE OR SEX. |
| 143 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE. |
| 144 | SHOULD BE BILLED BY PROVIDER OF SERVICE. |
| 145 | THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY. |

| EOB | DESCRIPTION |
|---|---|
| 146 | THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE. |
| 147 | PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER. |
| 148 | THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE. |
| 149 | THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBER'S AGE. |
| 150 | THIS PROCEDURE IS INVALID FOR THE MEMBER'S SEX. |
| 151 | CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE |
| 152 | PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY KENTUCKY MEDICAID. |
| 153 | PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 154 | PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER. |
| 155 | PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR I NDIVIDUAL PROVIDER NUMBER IN BILLING FIELD. |
| 156 | THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER. |
| 157 | PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY. |
| 158 | CLAIM DENIED DUE TO INJURY DIAGNOSIS. |
| 159 | MORE THAN ONE VISIT PER DETAIL DATE OF SERVICE NOT ALLOWED. EACH VISIT MUST BE |
| 160 | PROCEDURE INVALID FOR TOOTH NUMBER INDICATED. |
| 161 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE. |
| 162 | CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY. |
| 163 | CLAIM DETAIL DENIED. EMPLOYEE ID/PERSONAL IDENTIFIER MISSING OR INVALID. |
| 164 | PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE. |
| 165 | SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE. |
| 166 | CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 167 | SECONDARY SURGICAL PROCDURE CODE INVALID FOR MEMBERS AGE. |
| 168 | PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX. |
| 169 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX |
| 170 | PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 171 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 172 | SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 173 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 174 | PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE |
| 175 | PROVIDER ON REVIEW FOR SECONDARY SURGICAL PROCEDURE |
| 176 | SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW |
| 177 | SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW |
| 178 | EXPECTED DATE OF DELIVERY MUST BE AT LEAST 30 DAYS FROM DATE OF CONSENT. |
| 179 | CLAIM DENIED-PLEASE RESUBMIT CLAIM WITH REPORT OF PROCEDURE PERFORMED. |
| 180 | DETAIL PROCEDURE INDICATE AS ON REVIEW. |
| 181 | RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED. |

| EOB | DESCRIPTION |
|---|---|
| 182 | RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE. |
| 183 | RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED. |
| 184 | RESUBMIT WITH MAP-235 OR MAP-236 ATTACHED IF APPROPRIATE. |
| 185 | CONSENT FORM MUST BE SIGNED BY MEMBER 30 DAYS PRIOR TO STERILIZATION |
| 186 | STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY MEMBER. |
| 187 | STAMPED SIGNATURES ARE UNACCEPTABLE. |
| 188 | CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RE |
| 189 | CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATION |
| 190 | THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOS IS CODE AND RESUBMIT THE CLAIM. |
| 191 | THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. |
| 192 | THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE. |
| 193 | THE SECONDARY DIAGNOSIS IS INVALID FOR THE MEMBER'S AGE. |
| 194 | DIAGNOSIS IS INVALID FOR MEMBER'S SEX. |
| 195 | THE SECONDARY DIAGONSIS IS INVALID FOR MEMBER SEX. |
| 196 | THE BILLED DIAGNOSIS IS ON REVIEW. |
| 197 | CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH, |
| 198 | DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH. |
| 199 | CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999). |
| 200 | CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS. |
| 201 | INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. |
| 202 | INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. |
| 203 | CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT A |
| 204 | INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. |
| 205 | DIAGNOSIS CODE INVALID FOR PROVIDER TYPE |
| 206 | CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. |
| 207 | DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. |
| 208 | THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS |
| 209 | CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE |
| 210 | CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. |
| 211 | CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE. |
| 212 | CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. |
| 213 | THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. |
| 214 | CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. |
| 215 | CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS |
| 216 | CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. |
| 217 | THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. |

| EOB | DESCRIPTION |
|---|---|
| 218 | FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. |
| 219 | FOURTH HEADER DIAGNOSIS ON REVIEW. |
| 220 | SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY. |
| 221 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE. |
| 222 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE |
| 223 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE |
| 224 | CLAIM DENIED. MISSING OR INVALID DIAGNOSIS CODE. |
| 225 | NO HISTORY MATCH FOUND, PLEASE RESUBMIT. |
| 226 | CANNOT BEPROCESSED ON THIS CLAIM FORM. |
| 227 | CLAIM OVERLAPS YOUR FISCAL YEAR END. |
| 228 | THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE. |
| 229 | BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE. |
| 230 | THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE. |
| 231 | CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER |
| 232 | CLAIM/DETAIL DENIED. ACTION REASON CODE INDICATES PROVIDER IS ON REVIEW. |
| 233 | UPIN MISSING OR INVALID. |
| 234 | CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW. |
| 235 | SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM. |
| 236 | PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER. |
| 237 | CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE. |
| 238 | CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC. |
| 239 | DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE. |
| 240 | MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE. |
| 241 | PENDING CONFIRMATION OF PROVIDER ELIGIBILITY. |
| 242 | NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26. |
| 243 | PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS P |
| 244 | PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SE |
| 245 | THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER. |
| 246 | 80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAM |
| 247 | PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIGIBLE FOR THE DATE OF SERVIC |
| 248 | CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM. |
| 249 | PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT I N FACILITY FOR ALL OF |
| 250 | THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER. |
| 251 | INCORRECT MEMBER IDENTIFICATION NUMBER. |
| 252 | MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DAT ABASE FOR THE MAID NUMBER SUBMITTED ON YOUR CLAIM. |
| 253 | OUR RECORDS INDICATE THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVIC |

| EOB | DESCRIPTION |
|---|---|
| 254 | THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES. |
| 255 | MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES. |
| 256 | OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL |
| 257 | OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERV ICE. THE MEMBER IS NOT ELIGIBLE FOR THE SERVICE(S). |
| 258 | MEDICARE SUSPECT/DENTAL. |
| 259 | THE MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE. |
| 260 | CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS MEMBER. MEDICAID CLAIMS ARE NOT REIMBURSIBLE FOR THS M |
| 261 | OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR T O THE ENDING DATE OF |
| 262 | MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE. |
| 263 | CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE. |
| 264 | MEMBER NAME IS MISSING. |
| 265 | INCORRECT MEMBER IDENTIFICATION NUMBER. |
| 266 | MEMBER NOT ELIGIBLE FOR WAIVER SERVICES. |
| 267 | WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME |
| 268 | MEMBER ON REVIEW |
| 269 | CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENRO |
| 270 | CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER. |
| 271 | CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE CONTACT DMS AT 502-564-6885. |
| 272 | CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN |
| 273 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO CERTAIN TOOTH NUMBERS. |
| 274 | MEMBER TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE |
| 275 | INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID. |
| 276 | DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATI ON MEMBERS. |
| 277 | THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT |
| 278 | CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY |
| 279 | CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTER |
| 280 | CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCID ENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST. |
| 281 | MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENT |
| 282 | THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE. |
| 283 | OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE. |
| 284 | OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDIC ARE. PLEASE BILL MEDICARE FIRST. |
| 285 | REGIONAL ANESTHESIA PROCEDURE CODES MAY NOT BE BILLED USING TYPE OF SERVICE 07, |
| 286 | THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE. |
| 287 | PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHN |
| 288 | PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL |
| 289 | CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID. |

| EOB | DESCRIPTION |
|---|---|
| 290 | PENDING CONFIRMATION OF MEMBER ELIGIBILITY. |
| 291 | PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT. |
| 292 | CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW. |
| 293 | CLAIM SUSPENDED FOR ELIGIBILITY REVIEW. |
| 294 | KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMAR |
| 295 | BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHY |
| 296 | CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER. |
| 297 | MEMBER IS NOT ELIGIBLE FOR HOSPICE. |
| 298 | MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE. |
| 299 | HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FO R BILLED DATE(S) OF SERVICE. |
| 300 | SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS |
| 301 | CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP. |
| 303 | THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE. |
| 304 | OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVEL. |
| 305 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIO |
| 306 | A HOSPICE MEMBER - RECYCLE FOR EDIT 298. |
| 307 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJU |
| 308 | DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDIC |
| 310 | CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE. |
| 311 | CORRECTED PAYMENT PER ADJUSTMENT REQUEST. |
| 316 | CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTE |
| 319 | INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED. |
| 320 | CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS. |
| 321 | EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES. |
| 322 | EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROCEDURES. |
| 325 | CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 326 | CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM. |
| 327 | PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION. |
| 328 | PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION. |
| 329 | SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 330 | DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED. |
| 331 | PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE. |
| 333 | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION. |
| 334 | SUPPLY NOT COVERED ON RENTAL ITEM. |
| 335 | LACKS REPORT TO JUSTIFY HIGHER FEE. |
| 337 | CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROVIDER. |

| EOB | DESCRIPTION |
|---|---|
| 340 | ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FI |
| 341 | AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE |
| 342 | AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS SERVICE |
| 343 | CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE |
| 344 | AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM |
| 345 | 80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/ MEMBER/PROVIDER AS 80 |
| 347 | DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABLE |
| 348 | ROOM CHARGES REDUCED TO SEMI PRIVATE RATE. |
| 349 | EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS. |
| 350 | DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE O F SERVICE AS EMERGENCY SERVICES OR SEALANTS. |
| 351 | INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED. |
| 352 | CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED. |
| 353 | INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWA |
| 354 | MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB |
| 355 | FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT |
| 356 | CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS. |
| 357 | CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED. |
| 359 | REFER TO THE ADJUSTMENT REASON CODE. |
| 360 | FEE ADJUSTED PER CLAIM CREDIT. |
| 361 | GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SP |
| 362 | PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM. |
| 363 | ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION |
| 364 | PAYMENT REDUCED BY OTHER INSURANCE |
| 365 | FEE ADJUSTED TO MAXIMUM ALLOWABLE. |
| 366 | CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED $50.00 PER UNIT OF SERVICE. |
| 367 | THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE. |
| 368 | REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER. |
| 369 | ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE. |
| 370 | PAYMENT MODE NOT FOUND FOR BILLING PROVIDER |
| 371 | REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE |
| 372 | HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE. |
| 373 | UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY. |
| 374 | REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINAN |
| 375 | KYCONV-DESCRIPTION NOT FOUND |
| 376 | CLAIM DENIED. MAC FIELD INVALID. |
| 377 | MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM. |

| EOB | DESCRIPTION |
|---|---|
| 378 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED. |
| 379 | PAID BY MEDICAID |
| 380 | CO-PAY WAS DEDUCTED FROM REIMBURSEMENT. |
| 381 | CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT |
| 382 | DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN $100.00. |
| 383 | CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY. |
| 384 | DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES. |
| 385 | CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE |
| 386 | DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT. |
| 387 | CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE. |
| 388 | THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVEN UE CODE (240). CHARGES MOVED TO NON-COVERED. |
| 389 | PAID CLAIM BASED UPON MEDICAL REVIEW. |
| 390 | CLAIM DENIED. DUPLICATE SERVICE BILLED. |
| 391 | DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON THE |
| 392 | DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091. |
| 393 | CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE. |
| 394 | HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE S |
| 395 | THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REI |
| 396 | DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES. |
| 397 | ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM. |
| 398 | CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID. |
| 399 | CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS PE MEMBER. |
| 403 | PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE. |
| 404 | NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332. |
| 409 | INVALID PROVIDER TYPE BILLED ON CLAIM FORM. |
| 410 | FORMAT INVALID FOR ELECTRONIC CLAIMS. PLEASE CONTACT ECS HELP DESK AT 1-800-20 |
| 411 | DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERV |
| 412 | DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 413 | MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. |
| 414 | MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. |
| 415 | FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE. |
| 416 | CAPITATION RATE NOT WITHIN DATES OF SERVICE. |
| 417 | CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR. |
| 418 | CLAIM DENIED. INVALID ENCOUNTER TYPE. |
| 419 | CLAIM DENIED. INVALID ENC RECEIPT DATE. |
| 420 | CLAIM DENIED. INVALID ENC PAYMENT AMOUNT. |

| EOB | DESCRIPTION |
|---|---|
| 421 | CLAIM DENIED. INVALID ENC PAYMENT DATE. |
| 422 | CLAIM DENIED. INVALID ENC ADJUSTMENT TCN. |
| 423 | CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. |
| 424 | CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL. |
| 425 | DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE. |
| 426 | THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE |
| 427 | CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION F |
| 428 | FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE. |
| 429 | CLAIM DENIED. PARTNERSHIP NUM MISMATCH |
| 430 | CLAIM DENIED. ENCOUNTER, INV. TCN TO CREDIT |
| 431 | RESERVED FOR MANAGED CARE. |
| 432 | CLAIM DENIED. SEQ# MISMATCH ACROSS CLAIM. |
| 433 | CLAIM DENIED. VOID/RESUB INVALID FOR XOVER. |
| 434 | RESERVED FOR MANAGED CARE. |
| 435 | CLAIM/DETAIL DENIED. SCL WAIVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL P |
| 436 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS. |
| 437 | CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAY S PRIOR TO AN INPATIENT HOSPITAL ADMISSION (AND VICE VERSA). |
| 438 | CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER M EMBER, PER PROVIDER. |
| 439 | CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER CALENDAR WEEK, PER MEMBER, PER PROVIDER. |
| 440 | CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SU NDAY THROUGH SATURDAY). |
| 441 | CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER MEMBER. |
| 442 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME DATE OF S ERVICE AS PROCEDURE CODES 99244 AND 99245. |
| 443 | CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SA |
| 444 | PLEASE CORRECT INVALID OR MISSING NDC NUMBER. |
| 445 | CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PE R MEMBER, PER PROVIDER. |
| 446 | CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PE R MEMBER, PER PROVIDER. |
| 447 | CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY. |
| 448 | MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250. |
| 449 | THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAI |
| 450 | CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, |
| 451 | CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO |
| 452 | CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. |
| 453 | CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LI MITED TO 1 UNIT, CUMULATIVELY, PER DAY. |
| 454 | CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. |
| 455 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. |
| 456 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. |

| EOB | DESCRIPTION |
|---|---|
| 457 | CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATI VELY, PER DAY. |
| 458 | CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO $150.00 PER DAY. |
| 459 | CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CA |
| 460 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. |
| 461 | CLAIM/DETAIL DENIED. XL307/97535 LIMITED TO 80 UNITS PER WEEK. |
| 462 | PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. |
| 463 | PAY TPL CLAIM. |
| 464 | PAY AND BILL TPL CLAIM. |
| 465 | MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT). |
| 466 | DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER. |
| 467 | MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER. |
| 469 | CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK. |
| 472 | MEMBERS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRISCRIPTION/REFILL PER DATE OF |
| 473 | MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO. |
| 476 | MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE. |
| 477 | MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE. |
| 478 | YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION O |
| 479 | CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER. |
| 481 | CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED. |
| 482 | CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED. |
| 483 | DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST. |
| 484 | ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER. |
| 486 | DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM. |
| | ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS. |
| 489 | CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER. |
| 490 | CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY |
| 491 | CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE. |
| 492 | CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT |
| 493 | CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH |
| 494 | DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBE |
| 496 | ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER. |
| 497 | CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON UNISYS ADJUSTMENT REQUEST FORM. |
| 498 | CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE. |
| 499 | CLAIM PENDING REVIEW OF HISTORY. |
| 500 | CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS |
| 501 | PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER. |

| EOB | DESCRIPTION |
|---|---|
| 502 | ONE FAMILY PLANNING SERVICE PER DOS. |
| 503 | ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINI |
| 504 | FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD |
| 505 | MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE. |
| 506 | CBC AND COMPONENTS NOT ALLOWED SAME DOS. |
| 507 | PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS. |
| 508 | COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS. |
| 509 | MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDE |
| 510 | MEMBERS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVI |
| 511 | PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSE RTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE. |
| 512 | CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY. |
| 513 | CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION |
| 514 | CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY. |
| 515 | CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION. |
| 516 | EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED. |
| 517 | CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER |
| 518 | CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PR |
| 519 | CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INC |
| 520 | MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS. |
| 521 | COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIV |
| 522 | COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME. |
| 523 | RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME |
| 524 | IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAM |
| 525 | IN-PATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMIS |
| 526 | IN-PATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR |
| 527 | ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED. |
| 528 | ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN |
| 529 | CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE |
| 530 | CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE. |
| 531 | PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHEC |
| 532 | RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATIO |
| 533 | CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATI |
| 534 | CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER P |
| 535 | PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FOR |
| 536 | THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIG |
| 537 | CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI |

| EOB | DESCRIPTION |
|---|---|
| 538 | CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION. NO |
| 539 | CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVI |
| 540 | HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AU |
| 541 | CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMIT |
| 542 | DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS. |
| 543 | MULTIPLE SURGERIES FOR SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. YOUR |
| 544 | CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS. |
| 545 | MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. FILE AN ADJUSTMENT TO ADD ADDITIONAL PROCEDURES TO RELATED PA |
| 546 | CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) M |
| 547 | CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED. |
| 548 | CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185. |
| 549 | CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI |
| 550 | PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, AND SAME DATE OF SERVICE. |
| 551 | DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY. |
| 552 | THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY. |
| 553 | CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATE |
| 554 | THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT. |
| 555 | PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL. |
| 556 | CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY. |
| 557 | CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST |
| 558 | CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY. |
| 559 | CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC. |
| 560 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 567 | CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE. |
| 568 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. . |
| 569 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 570 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 571 | CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURI |
| 572 | DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PER |
| 573 | DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MON |
| 574 | CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 575 | REVENUE CODE INVALID FOR DATES OF SERVICE. |
| 576 | ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185. |
| 577 | CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER BY THE SAME OR DIFFERENTPRO |
| 578 | CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURI |
| 579 | CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY). |

| EOB | DESCRIPTION |
|---|---|
| 580 | CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF $1000.00 PER MEMBER FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED. |
| 581 | CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF EIGHT UNITS PER MEMBER, PER PREGNANCY. |
| 582 | CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF 76 UNITS PER MEMBER, PER PREGNANCY. |
| 583 | CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF 108 UNITS PER MEMBER, PER PREGNANCY. |
| 584 | CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED T O A COMBINED TOTAL OF 32 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SAURD |
| 585 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE C ODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER MEMBER, PER DAY. |
| 586 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE C ODES ARE LIMITED TO A COMBINED TOTAL OF 80 UNITS PER MEMBER, PER CALENDAR WEK ( |
| 587 | CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBI NED TOTAL OF 8 UNITS PER MEMBER, PER DAY. |
| 588 | CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBI NED TOTAL OF 45 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SATURDAY). |
| 589 | CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILL ED IN CONJUNTION WITH SUBSTANCE ABUSE CASE MANAGEMENT (DATES OF SERVICE WITHIN |
| 590 | HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY. |
| 591 | CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS INTENSIVE OUTPATIENT S |
| 592 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHA |
| 593 | CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH W B505, WB516, WB526/90862(UD), WB507, WB521, WB602/90804(UD), WB508, WB522, WB60 |
| 594 | CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION. |
| 596 | CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURG ICAL PROCEDURE. |
| 597 | CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY. |
| 598 | CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE. |
| 599 | CLAIM PENDING REVIEW OF HISTORY. |
| 600 | EYE EXAM LIMITED TO OPTOMETRIST. |
| 601 | ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS. |
| 602 | CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS |
| 603 | CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER. |
| 604 | NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SA ME DATE OF SERVICE. |
| 605 | ONLY FOUR PSYCHIATRIC PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER. |
| 606 | PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR TH E SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER. |
| 607 | EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER. |
| 608 | CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER,PER CALENDAR MONTH. |
| 609 | CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONTH PERIOD. |
| 610 | CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS. |
| 611 | MEMBER ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS. |
| 612 | ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER MEMBER. |
| 613 | RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS. |
| 614 | MEMBER ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE. |
| 615 | MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER |
| 616 | MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES |

| EOB | DESCRIPTION |
|---|---|
| 617 | MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS. |
| 618 | ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS. |
| 619 | MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR. |
| 620 | CLAIM DENIED. MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED. |
| 621 | DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED. |
| 622 | DETAIL DENIED. ANNUAL LIMIT OF $500.00 FOR MINOR HOME ADAPTIONS. |
| 623 | MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER. |
| 624 | CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER. |
| 625 | CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS. |
| 626 | CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER. |
| 627 | CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS. |
| 629 | MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS. |
| 631 | MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS. |
| 632 | FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY. |
| 633 | CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND |
| 634 | MAXIMUM $300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN. |
| 635 | AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER. |
| 636 | PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW ONE / 12 MOS / MEMBER. |
| 637 | CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANC |
| 638 | ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CL |
| 640 | THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS. |
| 641 | PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL. |
| 642 | THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER. |
| 644 | MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS. |
| 645 | NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS. |
| 646 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS. |
| 648 | MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS |
| 649 | MEMBER LMTD 1 INITIAL OPTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS. |
| 650 | ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT. |
| 652 | CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTHS |
| 653 | CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES. |
| 654 | MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER. |
| 655 | MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER |
| 656 | MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR. |
| 657 | MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR. |
| 658 | MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER |

| EOB | DESCRIPTION |
|---|---|
| 659 | MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER. |
| 660 | MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR. |
| 661 | CLAIM DENIED. READMISSION WITHIN 14 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH DOCUMENTATION NECESSITATING READMISSION ALONG WITH BOTH DIS |
| 662 | A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBER |
| 665 | VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLOWED SAME DOS/MEMBER/PROVIDER. |
| 666 | CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. |
| 667 | THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE. |
| 668 | DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SERVICE. |
| 669 | DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEM |
| 670 | DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER,PER CALENDAR YEAR. |
| 671 | CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY. |
| 673 | CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID. |
| 674 | PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS |
| 675 | CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 60 DAYS. |
| 676 | PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090. |
| 677 | PROCEDURE CODE LIMITED TO ONE PER 60 DAYS. |
| 678 | MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHAS |
| 679 | CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE. |
| 680 | FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE. |
| 681 | CLAIM DENIED. THIS HOSPITALIZATION IS RELATED TO A PREVIOUSLY PAID ADMISSION. |
| 682 | CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION. |
| 683 | MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE. |
| 684 | MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE O |
| 685 | CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE. |
| 686 | CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVED AYS PER MEMBER. |
| 687 | UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION. |
| 688 | MODEL WAIVER DOLLAR LIMIT HAS BEEN MET. |
| 689 | MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH P |
| 690 | CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER MEMBER. |
| 691 | CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID. |
| 692 | CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE |
| 693 | COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS. |
| 694 | COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME. |
| 695 | MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME. |
| 696 | CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-150 |
| 697 | MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS. |

| EOB | DESCRIPTION |
|---|---|
| 698 | MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER |
| 699 | CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $260.00 IN |
| 700 | CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE. |
| 701 | CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER MEMBERIE |
| 702 | CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER. |
| 703 | CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER MEMBER, PER PROVIDER. |
| 704 | CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER MEMBER, PER PROVIDER. |
| 705 | NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS. |
| 706 | NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO VIDER, PER 36 MONTHS/THREE YEARS. |
| 707 | NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS. |
| 708 | NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, P ER 36 MONTHS/THREE YEARS. |
| 709 | CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER. |
| 710 | CLAIM/DETAIL DENIED. ONLY ONE (1) CHEMOTHERAPY ADMIN CODE IS PAYABLE ON THE SA ME DATE OF SERVICE. IF QUESTIONS, PLEASE CONTACT THE DEPARTMENT FOR MEDICAID S |
| 711 | PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT |
| 712 | CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $265.00 PER CALENDAR M |
| 713 | DELIVERY, ROUTINE NEWBORN CARE, |
| 715 | CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, |
| 716 | CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, |
| 717 | CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PE |
| 718 | CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PRO VIDER, PER MEMBER, PER CALENDAR MONTH. |
| 719 | CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES ) ALLOWED PER PROVIDER, PER MEMBER, PER CALENDAR YEAR. |
| 722 | CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROVIDER, SAME DATE OF SERICE |
| 723 | CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER , PER DATE OF SERVICE, PER TOOTH NUMBER. |
| 724 | CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO $1000.00 IN PAYMENTS PER SIX MONTHS. |
| 725 | INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY,PER MEMBER,P ER PROVIDER. |
| 726 | CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVID ER, EVERY TWO YEARS. |
| 727 | CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFE TIME. |
| 728 | GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NU |
| 729 | PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLA R PER LIFETIME. |
| 730 | PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER. |
| 731 | MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS. |
| 732 | ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT, PER MEMBER, PER LIFETIME. |
| 733 | PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EAC H PER QUADRANT, PER MEMBER, PER 12 MONTH PERIOD, PER PROVIDER. |
| 734 | CLAIM/DETAIL DENIED.PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT. |
| 735 | CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER. |
| 736 | CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PRO VIDER, PER DATE OF SERVICE. |

| EOB | DESCRIPTION |
|---|---|
| 737 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER M EMBER. |
| 738 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER. |
| 739 | CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING. |
| 740 | CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE |
| 741 | CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICA L NECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATEMED |
| 742 | DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER P ROVIDER, PER 12 MONTHS. |
| 743 | GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVID ER. |
| 744 | CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SE RVICE PER DATE OF SERVICE. PLEASE CHECK THE UNITS OF SERVICE BILLED FOR ERRORS |
| 745 | CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PR |
| 746 | REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE. |
| 747 | CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS PER SEVEN DAY PERIOD. |
| 748 | REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE. |
| 749 | CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS. |
| 750 | DRUG/DRUG INTERACTION. |
| 751 | REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 752 | REVENUE CODE MISSING/INVALID. |
| 753 | INVALID REVENUE CODE. CHARGES NOT ALLOWED. |
| 754 | EARLY REFILL. |
| 755 | NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AF |
| 756 | CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED. |
| 757 | CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RT |
| 758 | PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON |
| 759 | PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. C |
| 760 | INFERRED DRUG/DISEASE PRECAUTION. |
| 761 | DRUG/AGE PRECAUTION. |
| 762 | MEDICAL CONDITION ALERT. |
| 763 | SERVICES RENDERED DO NOT MEET DMS CRITERIA |
| 764 | DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED. |
| 765 | THERAPEUTIC DUPLICATION. |
| 766 | REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED. |
| 767 | INGREDIENT DUPLICATION. |
| 768 | ALCOHOL PRECAUTION. |
| 769 | BREAST FEEDING PRECAUTION. |
| 770 | DRUG/FOOD INTERACTION. |
| 771 | DRUG/LAB CONFLICT. |
| 772 | CALL HELP DESK (1-800-807-1232). |

| EOB | DESCRIPTION |
|---|---|
| 773 | INVALID DUR CONFLICT CODE. |
| 774 | INVALID DUR INTERVENTION CODE. |
| 775 | INVALID DUR OUTCOME CODE. |
| 777 | CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS. |
| 778 | VARIANCE LIMIT MET. CLAIM PENDING REVIEW. |
| 781 | CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT |
| 782 | CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT |
| 783 | FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR |
| 784 | PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE |
| 785 | CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER |
| 786 | CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER |
| 788 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER |
| 789 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8) |
| 790 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER |
| 791 | CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY). |
| 792 | CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD |
| 793 | CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS. |
| 794 | CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER MEMBER. |
| 795 | CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITA TION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. |
| 796 | CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATI ON FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. |
| 797 | THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED |
| 798 | PROCEDURE CODE XZ299 IS LIMITED TO $150.00 PER CALENDAR MONTH PER MEMBER, PER P |
| 799 | REVENUE CODE 270 CANNOT EXCEED $2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH. |
| 800 | CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVI |
| 801 | CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X 0074 OR X0075. |
| 802 | PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE S AME DATE OF SERVICE AS PROCEDURES 09110/D9110 OR 00140/D0140. |
| 803 | MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271. |
| 808 | MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPP |
| 809 | DATE PRESCRIBED IS MISSING |
| 810 | HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING D |
| 811 | NDC IS MISSING |
| 812 | ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN BILLING FOR SUTURE OF WOUND. |
| 813 | QUANTITY DISPENSED IS INVALID. |
| 814 | MEMBER ID NUMBER IS INVALID. |
| 815 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVIC |
| 816 | CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PRO CEDURES, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROCEDURES TO THE DMS FOR R |

| EOB | DESCRIPTION |
|---|---|
| 818 | VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS |
| 820 | BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE E |
| 821 | CLAIM DETAIL DENIED. LIMITATION EXCEEDED. |
| 822 | X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES. |
| 824 | DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OT |
| 825 | DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER. |
| 826 | PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTA |
| 827 | THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE |
| 828 | CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIA |
| 829 | CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PRO |
| 830 | CLAIM DENIED. NO DRG FOUND. |
| 831 | CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE. |
| 832 | CLAIM DENIED. DRG CRITERIA NOT MET. |
| 833 | CLAIM DENIED. DRG INVALID AGE. |
| 834 | CLAIM DENIED. DRG INVALID SEX. |
| 835 | CLAIM DENIED. DRG INVALID DISCHARGE STATUS. |
| 836 | CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS. |
| 837 | CLAIM DENIED. DRG DENY 469 THROUGH 470. |
| 838 | PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER |
| 839 | RESERVED FOR DRG |
| 840 | PROCEDURE CODE HAS BEEN REBUNDLED. |
| 841 | BYPASS INDICATOR, GMIS INFORMATIONAL ONLY. |
| 842 | PROCEDURE CODE IS MUTUALLY EXCLUSIVE. |
| 843 | PROCEDURE CODE IS INCIDENTAL. |
| 844 | PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURESMENT. |
| 845 | VISIT IS WITHIN ONE DAY PRE OP RANGE. |
| 846 | PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE |
| 847 | PROCEDURE IS A BILATERAL OR DUPLICATE |
| 848 | PLEASE PAY SPECIFIED PROCEDURE CODES. |
| 849 | PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON. |
| 850 | PROCEDURE CODE IS INVALID FOR PATIENTS AGE. |
| 851 | PROCEDURE CODE IS INVALID FOR PATIENTS SEX. |
| 852 | GMIS - INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE. |
| 853 | PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS |
| 854 | MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS. |
| 855 | KYCONV-DESCRIPTION NOT FOUND |

| EOB | DESCRIPTION |
|---|---|
| 856 | PROCEDURE NOT INDICATED FOR A MALE |
| 857 | PROCEDURE NOT INDICATED FOR A FEMALE |
| 858 | CLAIM DENIED. COSMETIC PROCEDURE. |
| 859 | CLAIM DENIED. DUPLICATE PROCEDURE. |
| 860 | CLAIM DENIED. EXPERMENTAL PROCEDURE. |
| 861 | CLAIM DENIED. OBSOLETE PROCEDURE. |
| 863 | PROCEDURE CODES DOES NOT REQUIRE AN ASSTANT SURGEON |
| 864 | PROCEDURE CODE IS INVALID FOR LOCATION. |
| 865 | PROCEDURE CODE NEEDS TO BE REPLACED. |
| 866 | PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED. |
| 867 | PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED. |
| 868 | CLAIM/DETAIL DENIED.  PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS LIMITED TO ONE PER FOUR YEARS. |
| 873 | CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $400.00 PER CALENDAR YEAR HAS |
| 874 | CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $200.00 PER CALENDAR YEAR HAS |
| 875 | CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF $1500.00 PER |
| 876 | CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO $800.00 PER EAR, PER |
| 877 | CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE |
| 878 | CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS |
| 879 | CLAIM DENIED. PROCEDURE REQUIRES DOCUMENTATION |
| 880 | CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14 |
| 881 | CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14. |
| 882 | CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID |
| 883 | CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID. |
| 884 | CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL |
| 885 | CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE. |
| 886 | CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE BILLED. |
| 888 | GMIS-VISIT IS WITHIN THE POST OP RANGE. |
| 889 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE. |
| 890 | CLAIM/DETAIL DENIED.  THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES. |
| 891 | CLAIM/DETAIL DENIED.  THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE DIAGNOSIS CODES. |
| 893 | UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT. |
| 894 | DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET. |
| 896 | CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT. |
| 897 | CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS. |
| 898 | TOO MANY CLAIMS IN A CYCLE. |
| 899 | DENIED PER PROVIDER REQUEST. |

| EOB | DESCRIPTION |
|---|---|
| 900 | THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESU |
| 901 | DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM |
| 902 | CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES. |
| 903 | CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID. |
| 904 | CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE. |
| 905 | CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, P |
| 906 | PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FIL |
| 907 | CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE. |
| 908 | CLAIM\DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE |
| 909 | CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO. |
| 910 | CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO. |
| 911 | MODIFIER INVALID FOR PROCEDURE CODE BILLED. |
| 912 | CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED. |
| 913 | CLAIM DENIED.  OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED. |
| 914 | CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED. |
| 915 | CLAIM/DETAIL DENIED.  THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED  AMOUNT. |
| 916 | EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS  MEMBER. |
| 917 | CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 918 | CLAIM/DETAIL DENIED.  THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN TH E HEADER DATES OF SERVICE. |
| 919 | DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER 'S 21ST BIRTHDAY. |
| 920 | CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES. |
| 921 | CLAIM DENIED.  THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR  GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE. |
| 922 | THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM |
| 923 | CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PAT IENT'S ACCOUNT NUMBER FIELD ON THE CLAIM. |
| 924 | CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6THB IRTHDAY MUST BE SPLIT BILLED. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR |
| 925 | CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DA |
| 926 | CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS V |
| 927 | CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED. |
| 928 | DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED. |
| 929 | CLAIM/DETAIL DENIED.  ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE. |
| 930 | CLAIM/DETAIL DENIED.  MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE. |
| 931 | CLAIM DENIED. COMPOUND CODE MISSING OR INVALID. |
| 932 | CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR |
| 933 | CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID. |
| 934 | CLAIM DENIED DUE TO TRANSITION TO NEW SYSTEM. PLEASE RESUBMIT CLAIM. |
| 935 | DRUG INCOMPATABILITY ALERT. |

| EOB | DESCRIPTION |
|---|---|
| 936 | CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE. |
| 937 | CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD. |
| 938 | CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED |
| 939 | CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER |
| 941 | CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE. |
| 942 | CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE |
| 943 | CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2 |
| 944 | LOW DOSE ALERT. |
| 945 | HIGH DOSE ALERT. |
| 946 | LATE REFILL. |
| 947 | MINIMUM DURATION ALERT. |
| 948 | MAXIMUM DURATION ALERT. |
| 949 | DRUG ALLERGY ALERT. |
| 950 | CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMEN T FACILITY MEMBERS. |
| 951 | THIS SERVICE IS NOT COVERED BY MEDICAID. |
| 952 | REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT. |
| 953 | CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER. |
| 954 | CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID. |
| 955 | CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT. |
| 956 | THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE. |
| 957 | CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCE |
| 958 | EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST |
| 959 | PRIOR ADVERSE DRUG REACTION. |
| 960 | THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION R |
| 961 | THIS REV CODE IS NOT PAYABLE WHEN BILLED W/ ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE 240. CHARGES MOVED TO NON-COVERED. |
| 962 | PREGNANCY ALERT. |
| 963 | DRUG/GENDER ALERT. |
| 964 | CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 21. |
| 965 | CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO M |
| 966 | CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBER |
| 967 | CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY. |
| 968 | CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY. |
| 969 | THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD. |
| 970 | THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD |
| 971 | LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID. |
| 972 | CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY. |

| EOB | DESCRIPTION |
|---|---|
| 973 | PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DETAIL. |
| 974 | DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PRO |
| 975 | UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PROCEDURE |
| 976 | PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY. |
| 977 | TYPE OF BILL INVALID FOR PROVIDER TYPE. |
| 978 | CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM. |
| 979 | CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTE |
| 980 | COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO |
| 981 | CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR C ERTAIN PROCEDURE CODES, FOR DATES OF SERVICE AFTER 11/30/02. PLEASE VERIFY OUR |
| 982 | CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 F |
| 984 | MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE |
| 985 | DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE. |
| 986 | DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE. |
| 987 | DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP. |
| 988 | HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE A LLOWED AMOUNTS. |
| 989 | CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP. |
| 990 | DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRTHDAY |
| 991 | KYCONV-DESCRIPTION NOT FOUND |
| 992 | DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13. |
| 993 | CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE. |
| 994 | CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE |
| 996 | NUMBER OF STUDENTS IN GROUP MISSING OR INVALID. |
| 997 | CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN AD |
| 998 | CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED. |
| 999 | PENDING FOR REVIEW. |
| 1000 | INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON F |
| 1001 | INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER). |
| 1002 | COB - PAYER |
| 1003 | INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCAT |
| 1006 | FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED |
| 1010 | RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP. |
| 1011 | INTERNAL ERROR |
| 1016 | NON-PARTICIPATING MANUFACTURER |
| 1018 | NO PRICING SEGMENT FOR LEVEL OF CARE |
| 1037 | FACILITY PROVIDER I.D. NOT ON FILE |
| 1049 | BILLING PROVIDER IS SUSPENDED OR TERMINATED. |

| EOB | DESCRIPTION |
|---|---|
| 1052 | TAXONOMY CODE INVALID FOR RENDERING PROVIDER |
| 1053 | TAXONOMY CODE INVALID FOR PERFORMING PROVIDER |
| 1054 | TAXONOMY CODE INVALID FOR BILLING PROVIDER |
| 1055 | DTL REFERRING PROV NOT ON FILE |
| 1058 | NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM |
| 1059 | THIS SERVICE IS NOT A VALID ENCOUNTER UNDER THE SOONERCARE CHOICE PROGRAM UNLES |
| 1060 | NO RENDERING PROVIDER FOR CROSSOVER CLAIM |
| 1061 | NO FACILITY PROVIDER FOR CROSSOVER CLAIM |
| 1073 | CLAIM/SERVICE DENIED. THE BILLING PROVIDER SUBMITTED A CROSSOVER CLAIM THAT WAS |
| 1106 | THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE |
| 1112 | DETAIL DENIED. THE PROCEDURE BILLED HAS BEEN REBUNDLED TO A GLOBAL CPT-4 CODE |
| 1117 | CHRIS TEST |
| 1118 | THIS DRUG NOT COVERED BY MEDICARE PART D |
| 1121 | FOR QMB ONLY MEMBERS, THIS SERVICE IS NOT PAYABLE. FOR QDWI, QI1, QI2 AND SLMB |
| 1123 | THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE |
| 1129 | DETAIL DENIED. PROCEDURE BILLED WAS PERFORMED WITH A PRIMARY PROCEDURE. |
| 1606 | MISSING OR INVALID PAYER DATE |
| 1643 | INVALID OTHER COVERAGE CODE |
| 1652 | MISSING OR INVALID OTHER PAYER COVERAGE TYPE |
| 1800 | BILLING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KYH |
| 1801 | RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR K |
| 1802 | REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR K |
| 1803 | SERVICE FACILITY NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH |
| 1804 | DETAIL RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH |
| 1805 | DETAIL REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH |
| 1806 | BILLING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1807 | RENDERING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1808 | REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1809 | SERVICE FACILITY ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1811 | DETAIL RENDERING PROVIDER ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OFS |
| 1812 | DETAIL REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1814 | IF THE BILLING PROVIDER SUBMITS ANY OTHER SECONDARY NUMBER, POST THE EDIT. |
| 1815 | RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1816 | REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1817 | FACILITY PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1818 | OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |

| EOB | DESCRIPTION |
|---|---|
| 1819 | DETAIL RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1820 | DETAIL REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1821 | DETAIL OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM. |
| 1822 | RENDERING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1823 | REFERRING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1824 | SERVICE FACILITY PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1825 | OTHER PROVIDER 2 NPI NOT ON KY HEALTH CHOICES FILE |
| 1826 | DETAIL RENDERING PROVIDER NPI NOT ON FILE |
| 1827 | DETAIL REFERRING PROVIDER NPI NOT ON FILE |
| 1828 | DETAIL OTHER PROVIDER 2 NPI NOT ON FILE |
| 1829 | RENDERING PROVIDER NPI NOT ON FILE |
| 1830 | REFERRING PROVIDER NPI NOT ON FILE |
| 1831 | SERVICE FACILITY PROVIDER NOT ON FILE |
| 1832 | OTHER PROVIDER 2 NPI NOT ON FILE |
| 1833 | DETAIL RENDERING PROVIDER NPI NOT ON FILE |
| 1834 | DETAIL REFERRING PROVIDER NPI NOT ON FILE |
| 1835 | DETAIL OTHER PROVIDER 2 PROVIDER NPI NOT ON FILE |
| 1836 | BILLING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERV |
| 1837 | RENDERING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SE |
| 1838 | REFERRING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SE |
| 1839 | FACILITY NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SER |
| 1840 | OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATE |
| 1841 | RENDERING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE D |
| 1842 | REFERRING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE D |
| 1843 | OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FO |
| 1844 | KY HEALTH CHOICES BILLING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVI |
| 1845 | KY HEALTH CHOICES RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SE |
| 1846 | KY HEALTH CHOICES REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SE |
| 1847 | KY HEALTH CHOICES SERVICE FACILITY MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES |
| 1848 | KY HEALTH CHOICES OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES |
| 1849 | KY HEALTH CHOICES DETAIL RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES |
| 1850 | KY HEALTH CHOICES DETAIL REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES |
| 1851 | KY HEALTH CHOICES DETAIL OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAI |
| 1852 | WARNING - SUBMITTED BILLING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK |
| 1853 | WARNING - SUBMITTED RENDERING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHE |
| 1854 | WARNING - SUBMITTED REFERRING TAXONOMY CODE AT HEADER IS NOT VALID CODE - CHECK |

| EOB | DESCRIPTION |
|---|---|
| 1856 | WARNING - SUBMITTED DETAIL RENDERING TAXONOMY CODE AT HEADER IS NOT A VALID COD |
| 1857 | BILLING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1858 | RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1859 | REFERRING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1861 | DETAIL RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1862 | BILLING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE. |
| 1863 | RENDERING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1864 | REFERRING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1866 | RENDERING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1870 | BILLING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED |
| 1871 | REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSE |
| 1872 | RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSE |
| 1873 | SERVICE FACILITY PROV SUBMITTED NPI AND LEGACY NUM- LEGACY NUM NOT PROCESSED |
| 1874 | OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT P |
| 1875 | RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED |
| 1876 | REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSE |
| 1877 | OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT P |
| 1878 | PRESCRIBER'S NPI IS INVALID |
| 1879 | PRESCRIBER'S NPI IS MISSING |
| 1880 | PRESCRIBER'S NPI IS NOT ON FILE |
| 1900 | NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHC |
| 1901 | NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHC |
| 1902 | KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMI |
| 1903 | KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMI |
| 1904 | WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI IS |
| 1905 | WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI IS |
| 1906 | WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM AT |
| 1907 | WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM AT |
| 1908 | BILLING NPI ONLY SUBMITTED ON CLAIM. NPI IS NOT ON FILE |
| 1909 | TAXONOMY IS NOT VALID FOR FACILITY PROVIDER |
| 1910 | NPI ONLY SUBMITTED ON CLAIM AT HEADER ? NPI IS NOT ELIGIBLE FOR THE DATES OF SE |
| 1911 | NPI ONLY SUBMITTED ON CLAIM AT DETAIL ? NPI IS NOT ELIGIBLE FOR THE DATES OF SE |
| 1912 | WARNING - SUBMITTED TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VAL |
| 1913 | WARNING - SUBMITTED TAXONOMY CODE AT DETAIL IS NOT A VALID CODE - CHECK FOR VAL |
| 1914 | PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1915 | PROVIDER NPI NOT ON FILE |

| EOB | DESCRIPTION |
|---|---|
| 1916 | PROVIDER NPI NOT ON FILE |
| 1917 | PROVIDER NPI NOT ON FILE - DETAIL |
| 1918 | WARNING - BILLING PROVIDER 5 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED W |
| 1919 | WARNING - BILLING PROVIDER 5 + 4 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTER |
| 1920 | WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI ONLY MUST B |
| 1921 | WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT DETAIL - NPI ONLY MUST |
| 1922 | MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 DIGIT |
| 1923 | MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 + 4 D |
| 1924 | TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1925 | TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1926 | PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1927 | PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1936 | INVALID BILLING PROVIDER OVERRIDE SPECIFIED |
| 1937 | INVALID PERFORMING PROVIDER OVERRIDE SPECIFIED |
| 1938 | INVALID REFERRING PROVIDER OVERRIDE SPECIFIED |
| 1939 | INVALID FACILITY PROVIDER OVERRIDE SPECIFIED |
| 1940 | INVALID RENDERING PROVIDER OVERRIDE SPECIFIED |
| 1941 | INVALID OTHER PROVIDER 2 OVERRIDE SPECIFIED |
| 1942 | INVALID DTL OTHER PROVIDER 2 OVERRIDE SPECIFIED |
| 1943 | INVALID DTL PERFORMING PROVIDER OVERRIDE SPECIFIED |
| 1944 | INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED |
| 1945 | MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER |
| 1946 | MULTIPLE SERVICE LOCATIONS FOR PERFORMING PROVIDER |
| 1947 | MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER |
| 1948 | MULTIPLE SERVICE LOCATIONS FOR FACILITY PROVIDER |
| 1949 | MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER |
| 1950 | PROCEDURE INCLUDED IN BUNDLED RATE |
| 1951 | HCPC IS REQUIRED |
| 1952 | MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER |
| 1953 | MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER |
| 1955 | CLAIM/SERVICE DENIED. THE BILLING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT B |
| 1956 | CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE REFERRING PROVIDER. |
| 1957 | CLAIM/SERVICE DENIED. THE FACILITY PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT |
| 1958 | CLAIM/SERVICE DENIED. THE OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE |
| 1959 | CLAIM/SERVICE DENIED. THE PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNO |
| 1960 | CLAIM/SERVICE DENIED. THE DETAIL REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM |

| EOB | DESCRIPTION |
|---|---|
| 1961 | CLAIM/SERVICE DENIED. THE DETAIL OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CAN |
| 1962 | CLAIM/SERVICE DENIED. THE DETAIL PERFORMING PROVIDER NPI SUBMITTED ON THE CLAI |
| 1963 | CLAIM/SERVICE DENIED. THE KENPAC PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT |
| 1964 | THE LOCK IN PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE |
| 1965 | CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH THE NPI THAT CORRESPONDS TO YOUR KY M |
| 1966 | THE PROVIDER NPI AND TAXONOMY SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY |
| 1967 | THE PROVIDER NPI AND SERVICE FACILITY 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM C |
| 1968 | THE PROVIDER NPI AND SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CL |
| 1969 | THE PROVIDER NPI AND BILLING PROVIDER 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM C |
| 1970 | THE PROVIDER NPI AND BILLING PROVIDER 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLA |
| 1971 | THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED K |
| 1972 | THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED K |
| 1995 | MMIS FACILITY PROVIDER ID NOT ENROLLED |
| 1996 | THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM. |
| 1997 | THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICAID SYSTEM. PLEASE BILL FUTURE CLAIMS WITH THE PROVIDER NUMBER ASSIGNED DURING |
| 1999 | BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT |
| 2000 | ERROR DISPOSITION SETUP IS INVALID |
| 2001 | MEMBER ID NUMBER NOT ON FILE. |
| 2002 | MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE. |
| 2003 | MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE. |
| 2004 | PROCEDURE INCLUDED IN COMBINED PROCEDURE |
| 2005 | PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH |
| 2006 | RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA |
| 2007 | PA NOT AUTHORIZED FOR DRUG THERCLASS 46 & 47 |
| 2008 | EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE |
| 2009 | MEMBER INELIGIBLE ON DATE OF SERVICE. |
| 2010 | MULTIPLE ACTIVE PREVIOUS ID'S FOUND FOR MEMBER. |
| 2011 | MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE |
| 2012 | MAXIMUM CRITICAL CARE VISITS EXCEEDED |
| 2013 | EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE |
| 2014 | EXCEEDS MONTHLY CLINIC VISIT LIMITS |
| 2015 | SCHOOL BASED YEARLY LIMIT EXCEEDED |
| 2016 | LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR |
| 2017 | LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED |
| 2018 | DIABETIC SUPPLIES LIMITS EXCEEDED |
| 2019 | 12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED |

| EOB | DESCRIPTION |
|---|---|
| 2020 | YEARLY LIMIT FOR EYE GLASSES EXCEEDED |
| 2021 | 12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED |
| 2022 | A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE |
| 2023 | DEALER LIMITS EXCEEDED |
| 2024 | OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE |
| 2025 | EXCEEDS EARLY INTERVENTION SERVICES LIMITS |
| 2026 | EXCEEDS EPSDT CLINIC LIMITS |
| 2027 | EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS |
| 2028 | EXCEEDS NUTRITIONAL SERVICE FOR YEAR |
| 2029 | EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS |
| 2030 | SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE |
| 2031 | EXCEPTION CODE 031 |
| 2032 | MAXIMUM RENTAL PAYMENT |
| 2033 | HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS |
| 2034 | EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS |
| 2035 | THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED |
| 2036 | ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION |
| 2037 | MAXIMUM PAYMENT MADE |
| 2038 | EXCEEDS OXYGEN LIMITS-ONE PER MONTH |
| 2039 | TARGETED ULTRASOUND/AMNIOCENTISIS REVIEW |
| 2040 | THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED |
| 2041 | EXCEPTION CODE 041 |
| 2042 | EXCEEDS ONCE PER MONTH LIMIT |
| 2043 | ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD |
| 2044 | PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV. |
| 2045 | EXCEPTION CODE 045 |
| 2046 | EXCEPTION CODE 046 |
| 2047 | EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT |
| 2048 | CONFLICTING DENTAL SERVICE SAME DAY |
| 2049 | EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH |
| 2050 | EXCEPTION CODE 050 |
| 2051 | EXCEEDS 2 VISIT LIMIT |
| 2052 | NO LTC STAFFING SUBMITTED FOR SERVICE MONTH |
| 2053 | LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER |
| 2054 | PCS INELIGIBLE FOR CATEGORY OF SERVICE |
| 2055 | 2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED |

| EOB | DESCRIPTION |
|---|---|
| 2056 | TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED |
| 2057 | OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED |
| 2058 | YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED |
| 2059 | EXCEPTION CODE 059 |
| 206 | PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT |
| 2060 | EXCEPTION CODE 060 |
| 2061 | EXCEPTION CODE 061 |
| 2062 | EXCEPTION CODE 062 |
| 2063 | EXCEPTION CODE 063 |
| 2064 | EXCEPTION CODE 064 |
| 2065 | EXCEPTION CODE 065 |
| 2066 | EXCEPTION CODE 066 |
| 2067 | EXCEPTION CODE 067 |
| 2068 | EXCEPTION CODE 068 |
| 2069 | EXCEPTION CODE 069 |
| 2070 | 2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH |
| 2071 | THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER |
| 2072 | PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS |
| 2073 | EXCEPTION CODE 073 |
| 2074 | PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS |
| 2075 | MEMBER HAS OVERLAPPING PATIENT LIABILITY SEGMENTS. PLEASE CONTACT EDS PROVIDER |
| 2076 | EXCEEDS YEARLY FAMILY PLANNING EXAM LIMIT |
| 2077 | EXCEPTION CODE 077 |
| 2078 | MEMBER HAS MULTIPLE BENEFIT PLANS FOR THE DATE OF SERVICE RANGE. |
| 2079 | EXCEPTION CODE 079 |
| 2080 | PREVIOUSLY PAID AUDITORY EXAM IN 12 MONTHS |
| 2081 | CHILDRENS DAYS EXCEEDED |
| 2082 | CHILDRENS DAYS EXHAUSTED |
| 2083 | CHILDRENS VISITS EXCEEDED |
| 2084 | CHILDRENS VISITS EXHAUSTED |
| 2085 | CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED |
| 2086 | CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED |
| 2087 | TB DRUG |
| 2088 | EXCEPTION CODE 088 |
| 2089 | EXCEPTION CODE 089 |
| 2090 | PCS - 1500 |

| EOB | DESCRIPTION |
|---|---|
| 2091 | MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE. PLEASE CONTACT EDS. |
| 2092 | ALIEN-NO REQUEST FOR AUTHORIZATION RECEIVED |
| 2095 | REVIEW INVALID CARRIER DENIED BATCH |
| 2096 | DDSD HAS DENIAL/SUSPEND EDIT |
| 2098 | HCBW WAIVER HAS DENY/SUSPEND EDIT |
| 2099 | MANUALLY SUSPEND FOR HCA |
| 2101 | ADP WAIVER HAS DENY/SUSP EDIT |
| 2103 | PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE |
| 2104 | INVALID PROVIDER SPECIALTY FOR PROCEDURE |
| 2105 | INVALID DIAGNOSIS FOR PROCEDURE |
| 2106 | MEMBER NAME IS MISSING |
| 2110 | PCS CLAIM - MEMBER NOT PCS ELIGIBLE |
| 2112 | MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS |
| 2114 | OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW |
| 2115 | VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD |
| 2116 | EXCEPTION CODE 116 |
| 2117 | 2 YEAR RESUBMISSION DEADLINE EXCEEDED |
| 2118 | DISCHARGE DATE IS LESS THAN ADMIT DATE |
| 2119 | DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE |
| 2120 | VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD |
| 2121 | CLAIM WAS FILED WITHOUT SERVICING PROVIDER |
| 2122 | INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER |
| 2123 | INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER |
| 2124 | MISSING FIRST DATE OF SERVICE ON CLAIM |
| 2125 | ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG |
| 2126 | FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV |
| 2127 | DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV |
| 2128 | DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV |
| 2129 | MISSING MEMBER ID NUMBER ON CLAIM |
| 2130 | EXCEPTION CODE 130 |
| 2132 | MISSING TOTAL CLAIM CHARGE |
| 2133 | INVALID TOTAL CLAIM CHARGE |
| 2134 | INVALID NET CLAIM CHARGE |
| 2136 | MISSING/INVALID REVENUE CODE |
| 2138 | MISSING/INVALID TYPE OF BILL |
| 2140 | HCPC CODE IS INVALID FOR REVENUE CODE |

| EOB | DESCRIPTION |
|---|---|
| 2141 | TOTAL DAYS LESS THAN COVERED DAYS |
| 2142 | 1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED |
| 2143 | REFILLS EXHAUSTED |
| 2144 | INVALID REFILL INDICATOR VALUE |
| 2146 | HCPC/REVENUE CODE MISSING |
| 2147 | DIAGNOSIS NOT COVERED FOR THIS CLAIM TYPE FOR MEMBER'S BENEFIT PLAN |
| 2148 | PROCEDURE NOT PAYABLE THIS MEMBER |
| 2149 | PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER |
| 2150 | UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS |
| 2151 | MISSING PRESCRIBING PROVIDER NUMBER |
| 2152 | MISSING DRUG CODE |
| 2153 | INVALID DRUG CODE |
| 2154 | MISSING PRESCRIPTION NUMBER |
| 2155 | MISSING DRUG QUANTITY |
| 2156 | MISSING DAYS SUPPLY |
| 2160 | MISSING DIAGNOSIS INDICATOR |
| 2163 | MISSING DIAGNOSIS CODE |
| 2166 | MEMBER ELIGIBILITY PENDING DHS APPROVAL |
| 2167 | INVALID PATIENT STATUS |
| 2168 | INVALID SOURCE OF ADMISSION |
| 2170 | INVALID PLACE OF SERVICE |
| 2172 | CLAIM REQUIRES HCPC OR CPT-4 CODE |
| 2173 | ADMIT DATE GREATER THAN FIRST DATE OF SERVICE |
| 2174 | UNITS CANNOT BE LESS THAN DAYS |
| 2175 | SURGICAL PROCEDURE MISSING |
| 2176 | MEMBER NOT ON FILE PAY FROM STATE FUNDS |
| 2178 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2179 | MISSING TOOTH SURFACE |
| 2180 | INVALID TOOTH NUMBER |
| 2181 | INVALID TOOTH SURFACE |
| 2182 | MISSING TOOTH NUMBER |
| 2183 | MISSING UNITS OF SERVICE |
| 2184 | MISSING CHARGE |
| 2185 | LTC MISSING ADMISSION DATE |
| 2186 | INVALID ADMISSION HOUR |
| 2187 | PROCEDURE NOT PAYABLE THIS MEMBER |

| EOB | DESCRIPTION |
|---|---|
| 2189 | PROCEDURE REQUIRES MEDICAL REVIEW |
| 2190 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2191 | ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM |
| 2192 | TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN |
| 2193 | MISSING COVERED DAYS |
| 2194 | AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES |
| 2196 | MISSING ADMISSION DATE |
| 2197 | INVALID INPATIENT REVENUE CODE |
| 2198 | MISSING ATTENDING SURGEON PRESCRIBER NUMBER |
| 2199 | DATE OF SURGERY IS MISSING |
| 2200 | INVALID TYPE OF ADMISSION |
| 2201 | PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM |
| 2202 | SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE |
| 2203 | CLAIMANT SIGNATURE MISSING |
| 2204 | PROVIDER SIGNATURE IS MISSING |
| 2205 | PATIENT NOT CERTIFIED |
| 2206 | PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT |
| 2207 | INVALID LEVEL OF CARE |
| 2208 | INVALID PICKUP LOCATION |
| 2209 | INVALID DESTINATION |
| 2210 | FACILITY PROVIDER SERVICE LOCATION IS MISSING |
| 2213 | PREGNANCY INDICATOR INVALID |
| 2214 | DATE PRESCRIBED IS INVALID |
| 2215 | DATE DISPENSED IS MISSING |
| 2216 | DATE DISPENSED IS INVALID |
| 2222 | MISSING OCCURRENCE DATE |
| 2223 | SERVICE DATES ARE NOT IN SAME MONTH |
| 2224 | INVALID OCCURRENCE DATE |
| 2226 | INVALID CONDITION CODE |
| 2227 | EXCEPTION CODE 227 |
| 2228 | MISSING MEDICARE PAID DATE |
| 2230 | NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE |
| 2231 | ESTIMATED DAYS SUPPLY INVALID |
| 2233 | INSURANCE DENIAL REQUIRED |
| 2234 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2235 | SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE |

| EOB | DESCRIPTION |
|---|---|
| 2236 | SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE |
| 2237 | FACILITY PROVIDER NOT IN VALID FORMAT |
| 2238 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2239 | INVALID OCCURRENCE CODE |
| 2240 | THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING. |
| 2242 | MISSING OCCURRENCE CODE |
| 2244 | INVALID PAY-TO PROVIDER NUMBER |
| 2247 | MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED |
| 2249 | CLAIM HAS NO DETAILS |
| 2250 | MEMBER IS NOT ON ELIGIBILITY FILE |
| 2252 | MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES |
| 2253 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2254 | MEMBER NOT IN MANAGED CARE |
| 2258 | MEMBER IS NOT ON ELIGIBILITY FILE |
| 2259 | DATE BILLED IS INVALID |
| 2260 | SLIMB ONLY/NO MEDICAL ELIGIBILITY |
| 2262 | PROCEDURES NOT PAYABLE TB |
| 2263 | PROCEDURE REQUIRES REVIEW FOR TB MEMBER |
| 2265 | CLAIM HAS THIRD-PARTY PAYMENT |
| 2266 | REFERRING PHYSICIAN NUMBER IS MISSING |
| 2270 | INPATIENT TB NOT COVERED |
| 2271 | MEMBER IS NOT ELIGIBLE ON SERVICE DATE |
| 2272 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2273 | SUSPENDED FOR MEMBER REVIEW |
| 2274 | CLAIM INDICATES MEMBER EXPIRED |
| 2276 | NEWBORN-HCA REVIEW |
| 2277 | LTC ELIGIBILITY ERROR |
| 2278 | DISCHARGE DTE UNEQ TO LTC ELIG |
| 2281 | ABORTION NOT COVERED |
| 2282 | PHYSICIAN AUDITOR REVIEW-MODIFIER 24 |
| 2285 | MEMBER NOT ELIGIBLE FOR DATES OF SERVICE |
| 2287 | PROCEDURE NOT PAYABLE VR |
| 2289 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2290 | PROCEDURE IS NOT IN THE SCOPE OF THE PROGRAM |
| 2291 | PROCEDURE REQUIRES MEDICAL REVIEW |
| 2292 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |

| EOB | DESCRIPTION |
|---|---|
| 2294 | PROC REQUIRES REVIEW - HCBW |
| 2295 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2296 | PROVIDER INELIGIBLE FOR PROCEDURES |
| 2297 | PAY TO PROVIDER NOT ELIG FOR PAY-THIS DATE OF SERV |
| 2298 | PROVIDER NUMBER IS A GROUP NUMBER |
| 2300 | NO PROVIDER MASTER RECORD |
| 2302 | PRESCRIBING PROVIDER NOT ON FILE |
| 2303 | PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED. |
| 2304 | PROVIDER INELIGIBLE ON SERVICE DATE |
| 2305 | REVIEW CLAIMS FOR THIS PROVIDER |
| 2306 | PAY TO PROVIDER IS SUSPENDED |
| 2307 | BILLING OUT OF CLIA CERTIFICATE TYPE |
| 2308 | NO PAY-TO PROVIDER RECORD |
| 2309 | REVIEW CLAIM FOR PAY-TO- PROVIDER |
| 2310 | ANESTHESIA MODIFIER IS INVALID OR MISSING |
| 2311 | SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP |
| 2312 | PAY-TO PROVIDER NOT ENROLLED |
| 2313 | DIAGNOSIS CODE MISSING/NOT ON FILE |
| 2314 | SURGICAL PROCEDURE CODE NOT FOUND |
| 2315 | INVALID PRINCIPAL/OTHER PROCEDURE TYPE |
| 2316 | ATTACHMENT CONTROL NUMBER MISSING |
| 2317 | INVALID/MISSING MODIFIER FOR THIS PROCEDURE |
| 2318 | PROCEDURE REQUIRES MANUAL PRICING |
| 2319 | DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED |
| 2321 | PROCEDURE CODE IS NO LONGER VALID |
| 2322 | DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE |
| 2323 | INVALID MEMBER AGE FOR THIS DIAGNOSIS |
| 2324 | INVALID MEMBER SEX FOR THIS DIAGNOSIS |
| 2326 | INVALID TOOTH NUMBER FOR THIS PROCEDURE |
| 2327 | PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION |
| 2328 | PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE |
| 2329 | INVALID MEMBER SEX FOR THIS PROCEDURE |
| 2331 | THIS DRUG NOT COVERED FOR THE MEMBER |
| 2332 | INVALID PROVIDER TYPE FOR THIS PROCEDURE |
| 2335 | LTC MEMBER - NONCOMP DRUG |
| 2336 | REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS |

| EOB | DESCRIPTION |
|---|---|
| 2337 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2338 | LTC DRUG ONLY |
| 2341 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2342 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2345 | ATTENDING PROVIDER NOT FOUND |
| 2346 | REFERRING PROVIDER NOT FOUND |
| 2347 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2348 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 235 | PROCEDURE CODE NOT IN VALID FORMAT |
| 2350 | THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT. |
| 2351 | SUBMITTED TO ALLOWED EXCEEDS PERCENT |
| 2352 | ALLOWED TO SUBMITTED EXCEEDS PERCENT |
| 2354 | THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE |
| 2356 | NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED |
| 2357 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2358 | INACTIVE DRUG |
| 2359 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2360 | THIS NATIONAL DRUG CODE IS NOT ON FILE |
| 2361 | PROCEDURE CODE IS MISSING/NOT ON FILE |
| 2362 | MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM |
| 2366 | THIS DIAGNOSIS REQUIRES REVIEW |
| 2369 | MEDICARE COINSURANCE GREATER THAN MEDICARE PAID |
| 2371 | THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION |
| 2372 | ITEM NOT PAYABLE IN LONG TERM CARE FACILITY |
| 2374 | MISSING PRESCRIBER PROVIDER ON DEALER CLAIM |
| 2375 | SERVICE NOT ON EXPLANTION OF MEDICARE PAYMENTS |
| 2377 | MEMBER IS INELIGIBLE FOR THIS DRUG |
| 2379 | PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW |
| 2383 | MULTIPLE SURGERY REQUIRES REVIEW |
| 2385 | REVENUE CODE NOT ON FILE |
| 2388 | IMPROPER MODIFIER FOR CRNA |
| 2389 | THIS MODIFIER IS ALLOWED FOR CRNA ONLY |
| 2390 | MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE |
| 2391 | INVALID USE OF E DIAGNOSIS CODE |
| 2394 | VERIFY PCS TPL |
| 2396 | LOC ON CLAIM CONFLICTS WITH LOC ON FILE |

| EOB | DESCRIPTION |
|---|---|
| 2397 | INVALID LTC TERMINATION CODE |
| 2399 | REFERRING PROVIDER I.D. # IS NOT IN A VALID FORMAT |
| 2400 | INVALID LOC DAYS |
| 2401 | INVALID LEAVE DAYS |
| 2402 | INVALID TYPE OF LEAVE |
| 2406 | LTC LEAVE DATES CONFLICT |
| 2407 | THERAPEUTIC DAYS GT THAN 14 |
| 2410 | PA IS REQUIRED |
| 2411 | THERAPEUTIC DAYS USED EXCEEDS AUTHORIZATION |
| 2412 | DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 2413 | LTC BLOCK 13:TOTAL DAYS DO NOT EQUAL FROM/TO DAYS |
| 2414 | WAIVER SERVICES LONG TERM CARE CONFLICT |
| 2416 | AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE |
| 2417 | REVIEW AMBULANCE NON ROUTINE DESTINATION |
| 2420 | THIS DRUG NOT PAYABLE FOR MEMBER AGE |
| 2421 | THIS DRUG NOT PAYABLE FOR MEMBER SEX |
| 2425 | THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE |
| 2430 | LTC INVALID MEMBER ID NUMBER |
| 2431 | LTC NO PROV MASTER RECORD |
| 2433 | LTC MISSING PROVIDER NUMBER |
| 2434 | LTC INVALID PROV NUM CK-DIGIT |
| 2435 | LTC FIRST DATE OF SERVICE MISSING |
| 2436 | LTC FILING DEADLINE EXCEEDED |
| 2437 | LTC FIRST DATE GREATER LAST DATE |
| 2438 | LTC RECHECK SERVICE DATE |
| 2439 | LTC MISS MEMBER ID NUMBER |
| 2443 | LTC MEMBER NOT ON ELIG FILE |
| 2444 | LTC MEMBER INELIGIBLE ON SERVICE DATES |
| 2445 | LTC MEMBER NOT ELIGIBLE ON SERVICE DATES |
| 2446 | LTC MEMBER SUSPEND FOR REVIEW |
| 2447 | LTC PROV IS SUSPENDED |
| 2448 | LTC PROVIDER IS INELIGIBLE ON SERVICE DATES |
| 2449 | LTC REVIEW CLAIM FOR PROV |
| 2450 | INVALID QUADRANT |
| 2451 | LTC INV PROVIDER NUMBER |
| 2452 | RENDERING PROVIDER SERVICE LOCATION IS MISSING |

| EOB | DESCRIPTION |
|---|---|
| 2453 | INVALID DIAGNOSIS TREATMENT INDICATOR |
| 2454 | INVALID ASSIGNMENT CODE |
| 2456 | INVALID PROCEDURE TYPE |
| 2458 | ALIEN MEMBER ON REVIEW |
| 2459 | REVENUE CODES OP401 & OP403 NEED HCPC CODE |
| 2460 | CANNOT DETERMINE THE INPATIENT LEVEL OF CARE |
| 2461 | OCCURENCE CODE SPAN MISSING/INVALID |
| 2462 | INVALID/MISSING SPAN DATE |
| 2463 | SPAN THRU DATE LESS THAN SPAN FROM DATE |
| 2464 | SPAN DATE CONFLICT WITH DATES OF SERVICE SHOWN |
| 2465 | SPAN DATES OVERLAP |
| 2466 | SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS |
| 2468 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2469 | LTC MEMBER NAME/ID MISMATCH |
| 2470 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2471 | NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED |
| 2472 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2473 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2474 | DATE DISPENSED AFTER BILLING DATE |
| 2475 | DATE DISPENSED AFTER ICN DATE |
| 2476 | MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID |
| 2477 | THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT |
| 2478 | PCS MISSING SUBMITTED CHARGE |
| 2479 | CLIA OUT OF DATE |
| 2485 | DATE DISPENSED EARLIER THAN DATE PRESCRIBED |
| 2486 | INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION |
| 2487 | PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE |
| 2488 | ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE |
| 2489 | NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2490 | INPATIENT SERVICES ARE NOT COVERED FOR THIS MEMBER |
| 2491 | DRUG NOT APPROVED |
| 2492 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2493 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2494 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2495 | NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2496 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |

| EOB | DESCRIPTION |
|---|---|
| 2497 | NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE |
| 2498 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2499 | TPL PAY CHASE IMMUNO SUPPRESS DRUG |
| 2500 | TPL - PAY AND REPORT |
| 2501 | SUSPEND FOR TPL REVIEW |
| 2502 | FILE CLAIM WITH MEDICARE |
| 2503 | THIS PATIENT HAS OTHER INSURANCE |
| 2505 | CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT. |
| 2507 | EPSDT-MAY HAVE TPL |
| 2508 | TPL PAY AND CHASE PHARMACY |
| 2509 | TPL PAY AND CHASE PRE-NATAL |
| 2510 | THIS PATIENT HAS TWO COVERAGE TYPES |
| 2518 | PROVIDER TYPE - CLAIM INPUT CONFLICT |
| 2519 | DRUG REQUIRES PRIOR AUTHORIZATION |
| 2520 | DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED |
| 2522 | MEMBER IS NOT ELIGIBLE FOR THESE SERVICES |
| 2524 | OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE |
| 2526 | PCS PRIOR AUTHORIZATION NOT ON FILE |
| 2527 | PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES |
| 2528 | PCS PRIOR AUTHORIZATION UNITS USED |
| 2530 | TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE |
| 2532 | DISEASE STATE MANAGEMENT |
| 2533 | PDUR DRUG-ALLERGY INTERACTION |
| 2534 | PRODUR DRUG-AGE INTERACTION |
| 2535 | PDUR INGREDIENT DUPLICATION |
| 2536 | PDUR THERAPEUTIC DUPLICATION |
| 2537 | PDUR DRUG-TO-DRUG INTERACTION |
| 2538 | HMO CO-PAY/MEMBER HAS TPL |
| 2539 | PDUR EARLY REFILL ON PRESCRIPTION |
| 2540 | PDUR MINIMUM DURATION OF THERAPY |
| 2541 | PDUR DOSING PRECAUTION-HIGH DOSE |
| 2542 | PDUR DOSING PRECAUTION-LOW DOSE |
| 2543 | PDUR BREAST FEEDING/PREGNANCY PRECAUTION |
| 2544 | PDUR MAXIMUM DURATION OF THERAPY |
| 2545 | PDUR LATE REFILL ON PRESCRIPTION |
| 2546 | DRUG DISEASE MARKER |

| EOB | DESCRIPTION |
|---|---|
| 2547 | HMO CO-PAY/MEMBER HAS MEDICARE |
| 2548 | PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP |
| 2549 | ADJUSTMENT SUSPEND FOR MANUAL REVIEW |
| 2550 | SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER |
| 2552 | PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID |
| 2555 | CLAIM PAST 24 MONTH FILING - DTL |
| 2556 | MEMBER IS NOT WAIVER ELIGIBLE |
| 2557 | CLAIM PAST 24 MONTH FILING - HDR |
| 2560 | MEMBER SERVICES COVERED BY HMO PLAN |
| 2561 | PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY |
| 2562 | MEMBER PCPCM-CANNOT BILL OP/RHC/FQHC CLINICS RATE |
| 2563 | MEMBER NOT ENROLLED IN HMO FOR DOS |
| 2564 | SUPPLEMENTAL DELIVERY PYMT DENIAL CODE |
| 2566 | EXCEPTION CODE 566 |
| 2567 | HMO CO-PAY/NO TPL OR MEDICARE COVERAGE |
| 2569 | CC CLAIMS CAN'T PROCESS THRU SYSTEM |
| 2570 | INVALID ELIGIBILITY FOR HMO COPAY |
| 2571 | CLAIMCHECK REBUNDLED |
| 2572 | CC INCIDENTAL TO PRIMARY PROCEDURE |
| 2573 | CC MUTUALLY EXCLUSIVE |
| 2574 | CLAIMCHECK COSMETIC SURGERY |
| 2575 | CLAIMCHECK DUPLICATE |
| 2576 | CC UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED |
| 2577 | CLAIMCHECK POSSIBLE DUPLICATE |
| 2578 | CLAIMCHECK PRE-OP/POST-OP |
| 2579 | CC GROUPHEALTH SMARTSUSPENSE SUSPEND |
| 2580 | CLAIMCHECK MEDICAL/EVALUATION VISIT |
| 2581 | MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN |
| 2582 | MEMBER IS LOCKED-IN TO ANOTHER PHARMACY |
| 2583 | CLAIMREVIEW NEW VISIT FREQUENCY |
| 2584 | CC GROUPHLTH SMARTSUSPENSE DENY |
| 2587 | CLAIMREVIEW INTENSITY OF SERVICE |
| 2588 | STOP LOSS NOT APPROVED |
| 2589 | CC INVALID MODIFIER/PROCEDURE COMBINATION |
| 2590 | CLAIMCHECK EXCEEDS 40 LINES |
| 2591 | CLAIMREVIEW MULTIPLE/DUPLICATE COMP.BILLING |

| EOB | DESCRIPTION |
|---|---|
| 2592 | CLAIMCEHCK AGE REPLACEMENT |
| 2593 | CLAIMREVIEW DIAGNOSIS TO PROCEDURE |
| 2594 | CLAIMCHECK-BILL EACH DOS ON A SEPARATE LINE |
| 2595 | CLAIMCHECK AGE CONFLICT |
| 2597 | CLAIMCHECK MULTIPLE SURGERY |
| 2598 | CC-MULTIPLE SURGERY-DOUBLE MODIFIERS |
| 2599 | STOP LOSS THRESHOLD REACHED |
| 2600 | UNITS NOT EQUAL TO TEETH BILLED |
| 2601 | PART A CROSSOVER SPANS 20020501 |
| 2602 | UNITS NOT EQUAL TO TEETH BILLED |
| 2603 | PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA |
| 2604 | SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH |
| 2605 | PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH |
| 2606 | PRIOR AUTH UNITS/AMOUNTS USED |
| 2609 | CHECK CLAIM ATTACHMENT |
| 2612 | TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA |
| 2614 | DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS |
| 2615 | CLINIC RATE NOT ON FILE FOR HOSPITAL |
| 2616 | PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON |
| 2618 | AUTH SERVICES-MEMBER NOT ELIG |
| 2619 | MEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND |
| 2620 | MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM |
| 2622 | MASS CREDIT/ADJ BEING SUSPEND |
| 2623 | ADJUSTMENT HAS AUTO DENIAL |
| 2625 | FUND CODE UNDETERMINED |
| 2627 | COVERED FOR ORAL PATH ONLY |
| 2628 | DRUG REQUIRES PRIOR AUTHORIZATION/MN |
| 2630 | DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM |
| 2631 | DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM |
| 2632 | DIAGNOSIS NOT IN SCOPE OF CN PROGRAM |
| 2633 | DIAGNOSIS NOT IN SCOPE OF MN PROGRAM |
| 2634 | DETAIL ATTENDING PHYSICIAN ID INVALID |
| 2635 | DETAIL FIRST OTHER PHYSICIAN ID INVALID |
| 2636 | DETAIL SECOND OTHER PHYS ID INVALID |
| 2638 | DRUG REQUIRES MEDICAL REVIEW/CN |
| 2639 | DRUG REQUIRES MEDICAL REVIEW/MN |

| EOB | DESCRIPTION |
|---|---|
| 2642 | INVALID PROVIDER NUMBER |
| 2643 | ABORTION REQUIRES REVIEW |
| 2644 | PROCEDURE CODE MODIFIER NOT PAYABLE |
| 2646 | PROVIDER RATE NOT ON FILE |
| 2648 | CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE |
| 2649 | FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS |
| 2651 | INVALID TREATMENT DIAGNOSIS INDICATOR |
| 2652 | PCS-INVALID NET CLAIM CHARGE |
| 2653 | MEMBER ID IS INVALID FOR AUTH EXAM |
| 2654 | MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD |
| 2655 | ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH |
| 2657 | POTENTIAL DISABILITY CLAIM |
| 2659 | DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD |
| 2660 | ZERO AMOUNT TO PAY |
| 2673 | SUBMIT PAPER CLAIM |
| 2681 | PROVIDER INELIGIBLE ON DATE OF SERVICE |
| 2696 | CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY |
| 2697 | QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY |
| 2701 | PHYSICAN SIGNED CONSENT FORM BEFORE STERILIZATION |
| 2702 | DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM |
| 2703 | MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM |
| 2704 | REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION |
| 2705 | STERILIZATION CONSENT FORM IS NOT LEGIBLE |
| 2706 | DATE ON THE CONSENT FORM IS NOT LEGIBLE |
| 2707 | STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING |
| 2708 | PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM |
| 2709 | CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION |
| 2710 | CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION |
| 2711 | STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN |
| 2712 | CONSENT FORM IS NOT SIGNED BY THE MEMBER |
| 2713 | CONSENT FORM IS NOT SIGNED BY THE COUNSELOR |
| 2714 | CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED |
| 2715 | STERILIZATION CONSENT FORM IS INCOMPLETE |
| 2716 | HYSTERECTOMY CONSENT FORM REQUIRED |
| 2717 | STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN |
| 2718 | INVALID SURGICAL PROCEDURE CODE |

| EOB | DESCRIPTION |
|---|---|
| 2719 | REFILE CLAIM WITH OPERATIVE REPORT |
| 2720 | INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM |
| 2721 | FURTHER DESCRIPTION OF SERVICE REQUIRED |
| 2722 | STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ |
| 2723 | SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY |
| 2724 | REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES |
| 2725 | SERVICE NOT COVERED AS BILLED |
| 2726 | REFERRING PHYSICIAN REQUIRED |
| 2727 | ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES |
| 2728 | SERVICES ARE NOT AUTHORIZED |
| 2729 | DENIED AFTER SPECIAL REVIEW |
| 2730 | HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY |
| 2732 | COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER |
| 2733 | SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM |
| 2734 | PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION |
| 2735 | MEMBER INELIGIBLE ON SERVICE DATES |
| 2736 | MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW |
| 2737 | INVALID MODIFIER FOR THIS PROCEDURE |
| 2738 | INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE |
| 2739 | ONE AMBULATORY SURGERY ALLOWED PER DAY |
| 2740 | INVALID CODE FOR NARRATIVE DESCRIPTION |
| 2741 | INVALID SUBMITTED CHARGE |
| 2742 | AUTHORIZED PHYSICAL REQUIRES ABCDM-16 |
| 2743 | EXCEPTION CODE 743 |
| 2744 | AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16 |
| 2745 | REQUESTED ADDITIONAL INFORMATION NOT RECEIVED |
| 2746 | DENTAL X-RAYS ARE REQUIRED |
| 2747 | SERVICES ARE INCLUDED IN TOTAL PAID OB CARE |
| 2748 | PROCEDURE IS AN INCIDENTAL TO PAID MAJOR SURGERY |
| 2749 | OUTSIDE THE GUIDELINES OF THE MEDICAL PROGRAM |
| 2750 | EXCEEDS SUPPLY LIMIT/1 MONTH WITHIN 12 MONTHS |
| 2751 | EXCEPTION CODE 751 |
| 2752 | PER PHY MANUAL-USE 99202 ANTEPART WHEN NOT TOT. OB |
| 2753 | PROCEDURE IS INCIDENTAL MAJOR PROCEDURE ON CLAIM |
| 2754 | REFILE USING "MEMBER AREA" IN SQ CM |
| 2755 | REFILE CLAIM WITH PROOF OF TIMELY FILING ATTACHED |

| EOB | DESCRIPTION |
|---|---|
| 2756 | EXCEPTION CODE 756 |
| 2757 | TAKE HOME MEDICATION IS NOT PAYABLE |
| 2758 | PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER |
| 2759 | NEEDS COUNTY ADMIN AND/OR PROVIDER SIGNATURE |
| 2760 | MEMBER IS DECEASED THIS DATE OF SERVICE |
| 2761 | NAME ON SUBMITTED CLAIM DOES NOT MATCH DHS FILE |
| 2762 | FILE AN ASSIGNED MEDICARE CLAIM ON THIS PATIENT |
| 2763 | PCS - HEALTH CARE AUTHORITY WILL PROCESS CLAIM |
| 2764 | DUPLICATE OF PAID CLAIM |
| 2765 | INVALID HYSTERECTOMY CONSENT FORM |
| 2766 | STERILIZATION/HYSTERECTOMY CONSENT FORM IS INVALID |
| 2767 | EXCEPTION CODE 767 |
| 2768 | REQUEST ADJUSTMENT TO PAID CLAIM-PER MANUAL |
| 2769 | PAYMENT CORRECTED/SPENDDOWN-ADM12-HIST ONLY ADJUST |
| 2770 | INSURANCE PAYMENT MORE THAN ALLOWABLE |
| 2771 | SERVICE NOT PAYABLE THIS DATE OF SERVICE |
| 2772 | TYPE OF BILL-CLAIM CONFLICT |
| 2773 | AUTHORIZED ROOM & BOARD SERVICES ARE NOT ON CLAIM |
| 2774 | EXCEPTION CODE 774 |
| 2775 | CLAIM HAS BEEN FORWARED TO HCA |
| 2777 | SHOW MEDICARE PART B PAYMENTS |
| 2778 | HEALTH CARE AUTHORITY PROCESSED ADM12 |
| 2779 | ELIGIBILITY PROBLEM PROCESSED BY DHS |
| 2780 | RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS |
| 2781 | ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH |
| 2782 | PART OF INPATIENT HOSPITAL CHARGES |
| 2783 | PROCEDURE INCLUDED IN OFFICE CALL |
| 2785 | ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION |
| 2786 | SAME NDC/DATE PAID THIS PHARM |
| 2787 | ASST SURGEON MUST FILE OWN CLM |
| 2788 | CLINIC VISIT PAID THIS DATE |
| 2789 | PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN |
| 2790 | ABCDM-16/CLAIM PROV CONFLICT |
| 2791 | INVALID DIAGNOSIS FOR DESCRIPTION |
| 2792 | STERILIZATION CONSENT REQUIRED |
| 2793 | SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE |

| EOB | DESCRIPTION |
|---|---|
| 2794 | PAID CLAIM INCLUDED THIS PROCEDURE |
| 2795 | CC MUTUALLY EXCLUSIVE |
| 2796 | PATIENT HAS PRIVATE INSURANCE |
| 2797 | MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS |
| 2798 | REFILE WITH MEDICARE RECHECK HIC NUMBER |
| 2799 | EXCEPTION CODE 799 |
| 2800 | PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2801 | PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2802 | PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2803 | DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2804 | DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2806 | PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2807 | PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2808 | MEMBER IS ELIGIBLE FOR HOSPICE FOR A PORTION OF THE DATES OF SERVICE BILLED. P |
| 2812 | CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2813 | EXCEPTION CODE 813 |
| 2814 | CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2815 | LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM |
| 2816 | LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2820 | PCS-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2821 | PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2822 | EXCEPTION CODE 822 |
| 2823 | OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2824 | OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2826 | HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2827 | EXCEPTION CODE 827 |
| 2828 | HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2829 | INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2830 | INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2831 | EXCEPTION CODE 831 |
| 2832 | TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2833 | TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2835 | CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2836 | CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2838 | LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2839 | LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM |

| EOB | DESCRIPTION |
|---|---|
| 2842 | DEALER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2843 | DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2845 | OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2846 | OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2849 | INVALID MODIFIER COMBINATION |
| 2850 | LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM |
| 2851 | LTC-HOME HEALTH CLAIM CONFLICT |
| 2852 | LTC-PCS POSSIBLE CONFLICT |
| 2853 | PCS-LTC POSSIBLE CONFLICT |
| 2854 | INPATIENT-PCS POSSIBLE CONFLICT |
| 2855 | PCS-INPATIENT POSSIBLE CONFLICT |
| 2856 | HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM |
| 2857 | INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT |
| 2858 | INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM |
| 2859 | EXCEPTION CODE 859 |
| 2860 | CROSS CLAIM TYPE J CODE CONFLICT |
| 2877 | REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK |
| 2880 | PRODEDURE CODE NOT VALID FOR FORM |
| 2881 | HOME HEALTH-LTC CLAIM CONFLICT |
| 2882 | LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM |
| 2883 | CROSSOVER-PCS POSSIBLE CONFLICT |
| 2884 | PCS-CROSSOVER POSSIBLE CONFLICT |
| 2889 | PART-A COINSURANCE GREATER MEDICARE PD AMT |
| 2890 | REVIEW CROSSOVER PART B COINSURANCE OVER $1000.00 |
| 2893 | EXCEPTION CODE 893 |
| 2894 | RURAL HEALTH REVENUE REQUIRES HCPC CODE |
| 2895 | RURAL HEALTH CLINIC REQUIRES REVENUE OP521 |
| 2896 | FILE SEPARATE CLAIMS FOR DIFFERENT YEARS |
| 2900 | PCS DAYS REDUCED-INPT/LTC CONFLICT |
| 2901 | FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS |
| 2903 | MULTIPLE CPT CODES REQUIRED |
| 2904 | DENIED FOR OKLA FOUNDATION FOR PEER REVIEW AUDIT |
| 2905 | REFILE SEPARATE CLAIM FOR EACH MONTH |
| 2906 | MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS |
| 2907 | PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE |
| 2908 | ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE |

| EOB | DESCRIPTION |
|---|---|
| 2909 | FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER |
| 2910 | PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA |
| 2911 | SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT |
| 2912 | CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW |
| 2913 | CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW |
| 2914 | SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM |
| 2915 | PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM |
| 2916 | EXCEPTION CODE 916 |
| 2917 | CHARGES INDICATE ERROR IN MATH |
| 2918 | INDICATE UNITS WORKED NOT DAYS |
| 2919 | FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE |
| 2920 | WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION |
| 2921 | LIST EACH DATE SEPARATELY |
| 2922 | PATIENT RECEIVED SETTLE/BILL PATIENT |
| 2923 | ITEMIZE CHARGES FOR SUPPLIES |
| 2924 | CLIENT RESPONSIBLE EXCEEDS ALLOWABLE |
| 2925 | MEDICAL CONDITION/DIAGNOSIS NOT COVERED |
| 2926 | DME NAME BRAND DOES NOT MATCH ORDER NUMBER |
| 2927 | INDICATE EXACT UNITS PROVIDED FOR MEMBER |
| 2928 | WHOLESALER'S INVOICE REQUIRED FOR PAYMENT |
| 2929 | PROC/DIAG REQUIRE FEDERAL MANDATED STATMT-ABORTION |
| 2930 | PROCEDURE UNITS REDUCED TO ALLOWABLE |
| 2931 | EXCEPTION CODE 931 |
| 2932 | DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM |
| 2933 | ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS |
| 2934 | CLAIM WAS FILED WITH INVALID PROVIDER NUMBER |
| 2935 | RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH |
| 2936 | CONTACT CASE MANAGER OR SUPERVISOR |
| 2937 | PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE |
| 2938 | EXCEPTION CODE 938 |
| 2939 | REFILE ON PAPER CLAIM |
| 2940 | SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING |
| 2941 | REFILE WITH MEDICARE REMITTANCE STATEMENT |
| 2942 | DUPLICATE PAID THRU FINANCE |
| 2943 | REFILE ON ADM84-TRANSPORTATION CLAIM FORM |
| 2944 | DENIED AFTER CLAIM CHECK REVIEW |

| EOB | DESCRIPTION |
|---|---|
| 2945 | INVALID PROOF OF DENIAL/HMO |
| 2946 | INVALID PROOF OF INSURANCE DENIAL |
| 2947 | REFILE WITH CORRECT ADMIT DATE |
| 2948 | RESUBMIT LEGIBLE CLAIM/ATTACHMENT |
| 2949 | EXCEPTION CODE 949 |
| 2950 | THIS LEVEL TRANSPORTATION NOT REQUIRED |
| 2951 | DDSD WILL PROCESS CLAIM THROUGH FINANCE |
| 2952 | REFILE-NAME BRAND & PRODUCT/ORDER NUMBER FOR PRICE |
| 2953 | REFILE AS CROSSOVER WITH EOMP |
| 2954 | REFILE WITH APPROPRIATE EOMP |
| 2955 | NOT ELIGIBLE FOR WAIVERED SERVICES |
| 2956 | TPL PAID COLLECT FROM PATIENT |
| 2957 | NOT VERIFIED BY OPERATIVE REPORT |
| 2958 | ITEMIZE SURGERIES PER OPERATIVE REPORT |
| 2959 | CANNOT PROCESS NEGATIVE AMOUNTS |
| 2960 | ADJUSTED PER OFPR RECOMMENDATION |
| 2961 | NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN |
| 2962 | DOCUMENT OF NECESSITY/MRI REPORT REQUIRED |
| 2963 | DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE |
| 2964 | REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND |
| 2965 | PAY REMAINING DAYS ON PARAMETER FILE |
| 2966 | FILE MEDICARE PART A FOR INPATIENT SERVICES |
| 2967 | PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP |
| 2968 | REFILE AS PHARMACY WITH NATIONAL DRUG CODE |
| 2969 | NO MEDICAL JUSTIFICATION FOR TARGETED OB US |
| 2970 | SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION |
| 2971 | PARTIAL HOURS NON ACCEPTABLE |
| 2972 | NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL |
| 2973 | REFILE AS AMBULATORY SURGERY |
| 2974 | PRESCRIBING PROVIDER EXCLUDED |
| 2976 | HYSTERECTOMY REQUIRE SIGN DATE |
| 2977 | REFILE CLAIM WITH MEDICAL RECORD |
| 2978 | INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE |
| 2979 | NURSING HOME CLAIMS PAID THIS DATE OF SERVICE |
| 2980 | PROCEDURE NOT PAYABLE FOR THIS AGE |
| 2981 | VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE |

| EOB | DESCRIPTION |
|---|---|
| 2982 | REFILE WITH PHYSICIAN PROGRESS NOTES |
| 2983 | PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA |
| 2984 | DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE |
| 2985 | PROVIDER IS SUSPENDED OR TERMINATED |
| 2986 | UNITS CANNOT BE GREATER THAN 999 |
| 2987 | PRIOR AUTHORIZATION UNITS/AMOUNTS USED |
| 2988 | TB ONLY ELIGIBLE - NEED 'T' IN FORCE FIELD (FF) |
| 2989 | SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH |
| 2990 | SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER |
| 2991 | UNITS REDUCED PER DOCU/AFTER SURS REVIEW |
| 2993 | EXCEPTION CODE 993 |
| 2994 | EXCEPTION CODE 994 |
| 2995 | EXCEPTION CODE 995 |
| 2996 | EXCEPTION CODE 996 |
| 2997 | EXCEPTION CODE 997 |
| 2998 | EXCEPTION CODE 998 |
| 2999 | EXCEPTION CODE 999 |
| 3000 | UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTHORIZATION MASTER. |
| 3001 | PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL. |
| 3003 | SERVICE REQUIRES PRIOR AUTHORIZATION. |
| 3006 | DOLLARS EXCEED AUTHORIZED DOLLARS ON AUTHORIZATION MASTER. |
| 3037 | MEMBER NUMBER HAS BEEN DEACTIVATED |
| 3301 | TOTAL CLAIM BILLED EXCEEDS DOLLAR LIMIT ($99,000) |
| 3340 | UB-04 CLAIMS MUST INCLUDE AT LEAST ONE VALID REVENUE CODE. |
| 3354 | LTC PROVIDER NUMBER MUST BE ENTERED. |
| 3360 | TAXONOMY CODE INVALID |
| 3362 | PA NUMBER OR PA PAYMENT METHOD IS NOT VALID |
| 3371 | THE DISCHARGE HOUR IS MISSING OR INVALID. |
| 3382 | THIS DIAGNOSIS IS NOT PAYABLE FOR THIS PROVIDER TYPE. |
| 3595 | THE NUMBER OF UNITS BILLED FOR THIS PROCEDURE IS IN EXCESS OF THE THRESHOLD SET |
| 3600 | SERVICE NOT COVERED UNDER MEMBER'S PROGRAM. |
| 3999 | CLAIM BILLED WITH INACTIVE MID |
| 4000 | MORE THAN TWO SURGICAL UNITS ON THE CLAIM |
| 4002 | THIS NDC CODE IS NOT COVERED FOR THIS MEMBER. |
| 4003 | DRUG IS LESS THAN EFFECTIVE - DESI |
| 4014 | NO PRICING SEGMENT IS ON FILE. |

| EOB | DESCRIPTION |
|---|---|
| 4017 | THIS DRG IS NOT COVERED FOR THIS MEMBER. |
| 4019 | PROCEDURE CODE REQUIRES ATTACHEMENT. |
| 4020 | UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE |
| 4021 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4026 | NDC/DAYS SUPPLY LIMITATIONS. THIS NDC CODE BILLED MAY NOT BE GREATER THAN THE |
| 4029 | DIAGNOSIS AND PLACE OF SERVICE DO NOT MATCH FOR THE MEMBER'S BENEFIT PLAN |
| 4031 | GENDER RESTRICTION FOR BILLED DIAGNOSIS. |
| 4033 | INVALID PROCEDURE CODE MODIFIER COMBINATION |
| 4039 | DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS |
| 4063 | ICD*9 CM PROCEDURE CODE/AGE RESTRICTION. |
| 4064 | GENDER RESTRICTION FOR COVERED ICD*9. |
| 4065 | ICD*9 CM PROCEDURE REQUIRES ATTACHMENT. |
| 4067 | ICD-9 SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE |
| 4070 | MODIFIER RESTRICTION FOR REIMBURSEMENT RULE |
| 4077 | REVENUE CODE INVALID FOR DATE OF SERVICE. |
| 4089 | MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT |
| 4095 | NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL |
| 4098 | PRICING BEING REVIEWED |
| 4107 | REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PROVIDED |
| 4108 | NO ASC ON FILE |
| 4114 | PRICING BEING REVIEWED |
| 4115 | PRICING BEING REVIEWED |
| 4119 | VALUE CODE AMOUNT MISSING XYZ |
| 4120 | VALUE CODE IS MISSING |
| 4121 | PROCEDURE CODE REQUIRES TOOTH QUADRANT |
| 4122 | VALUE CODE IS INVALID |
| 4123 | VALUE CODE AMOUNT IS MISSING |
| 4124 | VALUE CODE AMOUNT IS INVALID |
| 4127 | CANNOT PRIORITIZE MEMBER'S PROGRAMS |
| 4140 | THIS PROVIDER MAY NOT BILL THIS SERVICE FOR THIS MEMBER. |
| 4141 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4142 | THIS REVENUE CODE IS NOT VALID FOR THIS PROVIDER CONTRACT. |
| 4188 | THIS QUADRANT CODE IS NOT VALID FOR THIS PROCEDURE CODE. |
| 4189 | THIS ARCH CODE IS NOT VALID FOR THIS PROCEDURE CODE. |
| 4203 | THIS SERVICE IS A NON-COVERED OKLAHOMA HEALTH COVERAGE PROGRAM SERVICE AS THE R ENDERING PROVIDER IS NOT RECOGNIZED BY THE OKLAHOMA HEALTH COVERAGE PROGRAM. |
| 4207 | CLIA NUMBER MISSING OR NOT ON FILE FOR DATE OF SERVICE. |

| EOB | DESCRIPTION |
|---|---|
| 4209 | NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED |
| 4211 | PROCEDURE CODE/TOOTH NUMBER COMBINATION IS MISSING OR INVALID. |
| 4215 | REVENUE CODE NOT VALID FOR THIS BILL TYPE |
| 4218 | INVALID PROCEDURE FOR CLAIM FORM |
| 4220 | EPOGEN REQUIRES VALUE CODE 68 |
| 4227 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER. |
| 4244 | THIS DIAGNOSIS IS NOT COVERED FOR THIS MEMBER. |
| 4246 | ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE |
| 4251 | DECIMAL UNITS NOT BILLABLE FOR PROCEDURE. |
| 4252 | DIAGNOSIS CODE 10-24 NOT ON FILE |
| 4253 | REVENUE CODE REQUIRES MEDICAL REVIEW |
| 4254 | REVENUE CODE VS AGE RESTRICTION |
| 4255 | ONE OR MORE MODIFIERS ON THIS DETAIL CAN ONLY BE BILLED FOR MEMBERS AGED 21 |
| 4257 | THIS PROCEDURE CODE/MODIFIER COMBINATION IS NOT COVERED FOR THIS PROVIDER CONTRACT |
| 4314 | DENIED. DIAGNOSIS CODE IS NOT COVERED. |
| 4318 | PRIMARY HEADER DX RESTRICTION FOR BILLED ICD*9 PROCEDURE. |
| 4371 | THIS SERVICE IS COVERED FOR QMB ONLY MEMBERS. |
| 4374 | DENIED. REVENUE CODE IS NOT COVERED. |
| 4376 | DENIED. ICD 9 SURGICAL PROCEDURE CODE(S) IS NOT COVERED. |
| 4381 | NO REIMBURSEMENT RULE ON FILE. |
| 4384 | THE PRIMARY DIAGNOSIS ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT. |
| 4385 | MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE CODE |
| 4386 | PROVIDER CONTRACT - PROCEDURE NOT BILLABLE WITH REVENUE CODE |
| 4387 | REIMBURSEMENT - PROCEDURE NOT PAYABLE WITH REVENUE CODE |
| 4391 | THE LENGTH OF STAY ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT. |
| 4393 | CONTRACT INVALID REVENUE/PROCEDURE COMBO |
| 4394 | UNABLE TO DETERMINE REGULAR MEDICAID CLAIM TYPE FOR CROSSOVER CLAIM |
| 4395 | PROVIDER CONTRACT - PROCEDURE - OOS NOT COVERED |
| 4396 | PROVIDER CONTRACT - REVENUE CODE - OOS NOT COVERED |
| 4397 | PROVIDER CONTRACT - DRG - OOS NOT COVERED |
| 4398 | PROVIDER CONTRACT - ICD9 PROC - OOS NOT COVERED |
| 4400 | THE NDC IS NOT NUMERIC OR NOT FOUND IN THE DRUG FILE |
| 4401 | THIS NDC IS NOT VALID FOR THE DRUG GROUP FOR THIS PROCEDURE |
| 4402 | THE NDC IS MISSING OR IS NOT VALID FOR THIS J-CODE |
| 4403 | THE NDC QUANTITY IS MISSING OR ZERO. |
| 4404 | AWP NOT ON FILE FOR NDC |

| EOB | DESCRIPTION |
|---|---|
| 4406 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY. |
| 4407 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY. |
| 4408 | A NATIONAL DRUG CODE (NDC) IS REQUIRED FOR THIS REVENUE CODE. |
| 4714 | AGE RESTRICTION FOR BILLED PROCEDURE. |
| 4760 | MEDICAL REVIEW RESTRICTION FOR BILLED ICD*9. |
| 4765 | THIS ICD*9 PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4801 | THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4802 | THE PROVIDER IS NOT ALLOWED TO BILL THIS DIAGNOSIS |
| 4804 | THIS REVENUE CODE IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4805 | THIS DRG IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4813 | MUST SUBMIT SPECIFIC DOCUMENTATION WHICH SUPPORTS THE PROCEDURE BEING PERFORMED |
| 4831 | NO REIMBURSEMENT RULE ON FILE. |
| 4882 | THIS DRG IS NOT COVERED FOR THIS MEMBER. |
| 4886 | DENIED. DRG IS NOT COVERED. |
| 4975 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER. |
| 4990 | THIS PROCEDURE CODE IS NOT COVERED FOR THIS MEMBER. |
| 5000 | THIS IS A DUPLICATE OF ANOTHER CLAIM. |
| 5001 | THIS IS A DUPLICATE OF ANOTHER CLAIM. |
| 5002 | THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT. |
| 5003 | THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL. |
| 5004 | REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL. |
| 5005 | REVERSAL NOT PROCESSED- MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER |
| 5006 | REVERSAL NOT PROCESSED, CLAIM OVER 60 DAYS - SUBMIT MANUAL ADJUSTMENT. |
| 5007 | THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJUSTMENT |
| 5010 | EXACT DUPLICATE - TOOTH SURFACE |
| 5100 | MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAVE BEEN PAID. NO ADDITIONAL VISITS WILL |
| 5101 | PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99213) |
| 5102 | PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99348) |
| 5110 | CLAIM DETAIL DENIED. MUST BILL INTRAORAL COMPLETE SERIES |
| 5200 | VENI/ARTERIAL PUNCTURE SAME DATE OF SERVICE AS MONITORED PROCEDURE. |
| 5203 | CBC MAY NOT BE PAID ON SAME DAY AS CBC COMPONENTS. |
| 5235 | PROC S5100 & REV 580 NOT BILLABLE SAME MEMBER SAME DOS |
| 5236 | MONTHLY DIALYSIS NOT PAYABLE FOR SAME DATE OF SERVICE AS DAILY. |
| 5241 | PROCEDURES ARE NOT PAYABLE IN 30 DAYS OF RELATED PROCEDURES. |
| 5269 | 09110/D9110 ON SAME DOS AS OTHER PROCEDURE. |
| 5271 | PAYMENT FOR PROCEDURE IS IN REIMBURSEMENT FOR SURGERY. |

| EOB | DESCRIPTION |
|---|---|
| 5272 | PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. |
| 5278 | GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. |
| 5290 | S5100 AND S5101 NOT BILLABLE SAME MEMBER SAME DOS |
| 5292 | HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. |
| 5295 | PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE |
| 5302 | PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE |
| 5303 | CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE WHEN BILL |
| 5400 | MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH. |
| 5417 | FLUORIDE MUST BE BILLED IN CONJUSTION WITH PROPHY |
| 5422 | PERI AND ROOT SCALING NOT ALLOWED SDOS AS PROPHY |
| 5500 | STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG |
| 5632 | LAP HYSTER NOT BILLABLE WITH OTHER HYSTER PROC |
| 6200 | MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALE |
| 6205 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER |
| 6210 | PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REI |
| 6211 | PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER |
| 6220 | CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS CUMMULATIVELY PER C |
| 6304 | DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO $4000.00 PER CALENDAR YEAR. |
| 6305 | ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO $500.00 PER CALENDAR PE |
| 6306 | FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALEND |
| 6308 | COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC |
| 6309 | ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALEND |
| 6310 | NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTC |
| 6318 | ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO $2000.00 PER CALENDAR YEAR |
| 6319 | FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. |
| 6320 | THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. |
| 6321 | PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEM |
| 6323 | OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMB |
| 6324 | SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS. |
| 6325 | PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS. |
| 6326 | RESPITE SERVICES ARE LIMITED TO 1,440 HOURS PER MEMBER, PER CALENDAR YEAR FOR A |
| 6327 | ADULT DAY HEALTH CARE IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEM |
| 6328 | CLAIM/DETAIL DENIED. PROCEDURE(S) LIMITED TO FOUR UNITS PER DATE OF SERVICE. |
| 6329 | THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER. |
| 6330 | THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER. |
| 6331 | THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER, PER LOWER QUADRANT. |

| EOB | DESCRIPTION |
|---|---|
| 6514 | HOME HEALTH LIMITS EXCEEDED FOR 1 MONTH |
| 6554 | WAIVER LIMIT FOR PHARMACY HAS BEEN REACHED |
| 6660 | THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED. |
| 6661 | PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMP |
| 6700 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE |
| 6701 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE |
| 6702 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE |
| 6703 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 60 DAYS OF SURGICAL PROCEDURE |
| 6704 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE |
| 6726 | DENTAL PROPHY/FLUORIDE LIMITED TO 2 PER 351 DAYS |
| 6742 | PROCEDURE CODE D1206 IS LIMITED TO ONE UNIT PER 90 DAYS. |
| 6743 | PROCEDURE CODE D1206 IS LIMITED TO TWO UNITS PER YEAR. |
| 6744 | THIS SERVICE IS LIMITED TO 64 UNITS PER DAY OR IN COMBINATION WITH OTHER SELECT |
| 6746 | THIS PROCEDURE LIMITED TO 1 PER MEMBER PER FOUR YRS |
| 6749 | S5100 LIMITED TO 24 UNITS PER CALENDAR DAY |
| 6750 | S5100 LIMITED TO 120 UNITS PER CALENDAR WEEK |
| 6753 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBUR |
| 6764 | PROCEDURE CODE LIMITED TO 1 PER 12 MONTHS PER MEMBER, PER PROVIDER |
| 6765 | INITIAL VISIT LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS |
| 7000 | CLAIM FAILED A PRODUR ALERT |
| 7001 | CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT |
| 7002 | DENIED FOR PRODUR REASONS |
| 7020 | UNABLE TO DETERMINE THE COINS AND DED, RESUBMIT ON PAPER WITH EOMB |
| 7200 | MISCELLANEOUS CLAIMCHECK ERROR |
| 7201 | PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR |
| 7202 | PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS |
| 7203 | PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS |
| 7204 | PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS |
| 7205 | PROCEDURE IS NOT INDICATED FOR A MALE |
| 7206 | PROCEDURE IS NOT INDICATED FOR A FEMALE |
| 7207 | PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE |
| 7208 | PROCEDURE IS AN UNLISTED PROCEDURE |
| 7209 | PROCEDURE IS CLASSIFIED AS EXPERIMENTAL |
| 7210 | PROCEDURE IS CLASSIFIED AS OBSOLETE |
| 7211 | PROCEDURE IS INVALID FOR PATIENT'S AGE |
| 7212 | PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (AGE) |

| EOB | DESCRIPTION |
|---|---|
| 7213 | PROCEDURE IS INVALID FOR PATIENT'S SEX |
| 7214 | PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX) |
| 7215 | PROCEDURE CODE IS INCIDENTAL |
| 7216 | VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT |
| 7217 | PROCEDURE CODE HAS BEEN REBUNDLED |
| 7218 | PROCEDURE ADDED DUE TO REBUNDLING |
| 7219 | PROCEDURE IS MUTUALLY EXCLUSIVE |
| 7220 | PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE |
| 7221 | PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE |
| 7222 | PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON |
| 7223 | PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON |
| 7233 | DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL |
| 7234 | DENIED DUPLICATE - IS BILATERAL |
| 7235 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME |
| 7236 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY |
| 7237 | DENIED DUPLICATE (REBUNDLED) |
| 7238 | PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING |
| 7239 | PROCEDURE IS A POSSIBLE DUPLICATE |
| 7240 | SMARTSUSPENSE SUSPEND |
| 7241 | SMARTSUSPENSE DENIAL |
| 7242 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED |
| 7243 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED |
| 7244 | MEDICAL VISIT DENIED |
| 7245 | PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT |
| 7246 | PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT |
| 7247 | PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT |
| 7248 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS |
| 7249 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT |
| 7250 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT |
| 7251 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7252 | DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7253 | DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7254 | DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7255 | DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7256 | MODIFIER 51 INVALID FOR PRIMARY PROCEDURE |
| 7257 | MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE |

| EOB | DESCRIPTION |
|---|---|
| 7258 | REVIEW MODIFIER 51 |
| 7259 | SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS |
| 7260 | MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING |
| 7261 | INVALID PROCEDURE CODE |
| 7262 | DOB CANNOT BE GREATER THAN DATE OF SERVICE |
| 7263 | DOS REQUIRED FOR PROCEDURE |
| 7264 | DOS CANNOT BE A FUTURE DATE |
| 7265 | BIRTHDATE CANNOT BE A FUTURE DATE |
| 7266 | AGE CANNOT BE GREATER THAN 124 YEARS |
| 7267 | ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES |
| 7268 | PROVIDER IS REQUIRED FOR HISTORY PROCEDURES |
| 7269 | MODIFIER NOT VALID FOR THIS PROCEDURE |
| 7270 | INVALID MODIFIER/PROCEDURE CODE COMBINATION |
| 7271 | CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID |
| 7272 | DIAGNOSIS 1 MUST BE A VALID CODE |
| 7273 | DIAGNOSIS 2 MUST BE A VALID CODE |
| 7274 | DIAGNOSIS 3 MUST BE A VALID CODE |
| 7275 | DIAGNOSIS 4 MUST BE A VALID CODE |
| 7276 | DIAGNOSIS MUST BE A VALID CODE |
| 7277 | PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE |
| 7278 | INVALID DATE (DATE OF BIRTH) |
| 7279 | INVALID AMOUNT CHARGED |
| 7280 | CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED |
| 7281 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE |
| 7282 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS |
| 7283 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT |
| 7284 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT |
| 7285 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7286 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7287 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7288 | SMARTSUSPENSE FLAG |
| 7289 | SMARTSUSPENSE MONITOR |
| 7290 | MODIFIER 51 DELETED FOR PRIMARY PROCEDURE |
| 7291 | MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE |
| 7499 | MEMBER LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER |
| 7500 | YOUR CLAIM IS BEING REVIEWED |

| EOB | DESCRIPTION |
|---|---|
| 7501 | YOUR CLAIM IS BEING REVIEWED. |
| 7502 | MEMBER LOCKED IN TO A SPECIFIC PROVIDER |
| 7503 | MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALER |
| 7504 | MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT |
| 7505 | MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B. |
| 7506 | RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. CONTACT COLLEGE |
| 7507 | VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED |
| 7508 | Quantity dispensed on response claim same as original claim |
| 7509 | RENDERING PROVIDER ON PREPAYMENT REVIEW |
| 8000 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR. |
| 8001 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER. |
| 8002 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE. |
| 8003 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR. |
| 8004 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY. |
| 8005 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN. |
| 8006 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR. |
| 8007 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR. |
| 8008 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR |
| 8019 | PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR. |
| 8020 | SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT. |
| 8021 | SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER. |
| 8022 | SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER. |
| 8023 | SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE |
| 8024 | SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE. |
| 8025 | SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT. |
| 8026 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE. |
| 8027 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE. |
| 8028 | SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE. |
| 8030 | PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR. |
| 8031 | PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE. |
| 8032 | PROVIDER REQUESTED OFFSET DUE MEDICARE. |
| 8033 | PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY. |
| 8034 | PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN. |
| 8035 | PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY. |
| 8036 | PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP |
| 8037 | PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR. |

| EOB | DESCRIPTION |
|---|---|
| 8038 | PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR |
| 8039 | YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM. PLEASE RESUBMIT YOUR ORIGINAL CLAIM, WITH CORRECTIONS, FOR PROCESSING. |
| 8040 | PROVIDER INITIATED INTERNET ADJUSTMENT |
| 8041 | ADJUSTMENT REQUEST DENIED. PLEASE CORRECT ERROR AND SUBMIT ANOTHER ADJUSTMENT- |
| 8042 | SAVE FOR FUTURE USE. |
| 8043 | SAVE FOR FUTURE USE. |
| 8044 | SAVE FOR FUTURE USE. |
| 8045 | SAVE FOR FUTURE USE. |
| 8046 | SAVE FOR FUTURE USE. |
| 8047 | SAVE FOR FUTURE USE. |
| 8048 | SAVE FOR FUTURE USE. |
| 8049 | SAVE FOR FUTURE USE. |
| 8050 | SAVE FOR FUTURE USE. |
| 8051 | SAVE FOR FUTURE USE. |
| 8052 | SAVE FOR FUTURE USE. |
| 8053 | SAVE FOR FUTURE USE. |
| 8054 | SAVE FOR FUTURE USE. |
| 8055 | SAVE FOR FUTURE USE. |
| 8056 | SAVE FOR FUTURE USE. |
| 8057 | SAVE FOR FUTURE USE. |
| 8058 | SAVE FOR FUTURE USE. |
| 8059 | PROVIDER SENT A FULL REFUND DUE TO COST SETTLEMENT (REQ FYE) |
| 8060 | PROVIDER SENT REFUND DUE TO BILLING ERROR. |
| 8061 | PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR. |
| 8062 | PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT. |
| 8063 | PROVIDER SENT REFUND DUE TO MEMBER/RELATIVE PAID. |
| 8064 | PROVIDER SENT REFUND DUE TO MEDICARE PAID, |
| 8065 | PROVIDER SENT REFUND DUE TO CASUALTY INSURANCE PAID. |
| 8066 | PROVIDER SENT REFUND DUE TO HEALTH INSURANCE PAID. |
| 8067 | PROVIDER SENT REFUND DUE TO SURS REVIEW. |
| 8068 | PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW. |
| 8069 | PROVIDER SENT REFUND DUE TO PAID WRONG VENDOR. |
| 8070 | PROVIDER SENT REFUND DUE TO MEDICAID FRAUD. |
| 8071 | PROVIDER SENT REFUND DUE TO MEDICAID ABUSE. |
| 8072 | PROVIDER SENT REFUND DUE TO AUTO INSURANCE PAID. |
| 8073 | PROVIDER SENT REFUND DUE TO WORKERS COMPENSATION PAID. |

| EOB | DESCRIPTION |
|---|---|
| 8074 | PROVIDER SENT REFUND FOR ICN NOT IN HISTORY. |
| 8075 | PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR OTHER UNSPECIFIED ERROR. |
| 8076 | PRV REFUND - OTHER TPL REASON |
| 8077 | PRV REFUND - PSYCH CROSSOVER |
| 8079 | SAVE FOR FUTURE USE. |
| 8080 | SAVE FOR FUTURE USE. |
| 8081 | SAVE FOR FUTURE USE. |
| 8082 | NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR. |
| 8083 | NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE. |
| 8084 | NON-CLAIM SPECIFIC REFUND DUE TO SURS. |
| 8085 | NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR. |
| 8086 | SAVE FOR FUTURE USE. |
| 8087 | SAVE FOR FUTURE USE. |
| 8088 | SAVE FOR FUTURE USE. |
| 8101 | SAVE FOR FUTURE USE. |
| 8102 | SAVE FOR FUTURE USE. |
| 8103 | SAVE FOR FUTURE USE. |
| 8104 | SAVE FOR FUTURE USE. |
| 8105 | SAVE FOR FUTURE USE. |
| 8106 | SAVE FOR FUTURE USE. |
| 8107 | SAVE FOR FUTURE USE. |
| 8135 | EDS INITIATED OFFSET DUE TO PROCESSING ERROR |
| 8136 | EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR |
| 8141 | SAVE FOR FUTURE USE. |
| 8142 | SAVE FOR FUTURE USE. |
| 8143 | SAVE FOR FUTURE USE. |
| 8144 | SAVE FOR FUTURE USE. |
| 8145 | SAVE FOR FUTURE USE. |
| 8146 | SAVE FOR FUTURE USE. |
| 8147 | SAVE FOR FUTURE USE. |
| 8148 | SAVE FOR FUTURE USE. |
| 8149 | SAVE FOR FUTURE USE. |
| 8166 | EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR. |
| 8167 | EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR. |
| 8179 | YOUR VOID TRANSACTION HAS BEEN PROCESSED |
| 8180 | MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE. |

| EOB | DESCRIPTION |
|---|---|
| 8181 | MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE |
| 8182 | MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE. |
| 8183 | MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE. |
| 8184 | MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE |
| 8185 | MASS ADJUSTMENT - RETROACTIVE RATE CHANGE. |
| 8186 | MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE). |
| 8187 | OTHER REQUEST FOR MASS ADJUSTMENT |
| 8188 | VOID TRANSACTIONS - MASS ADJUSTMENT |
| 8189 | MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED |
| 8190 | MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED |
| 8191 | MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST |
| 8199 | SAVE FOR FUTURE USE. |
| 8200 | TPL PRIVATE HEALTH INSURANCE - CARRIER |
| 8201 | TPL PRIVATE HEALTH INSURANCE - PROVIDER |
| 8202 | TPL PRIVATE HEALTH INSURANCE - MEMBER |
| 8203 | AUTO LIABILITY - CARRIER |
| 8204 | AUTO LIABILITY - PROVIDER |
| 8205 | AUTO LIABILITY - MEMBER |
| 8206 | NON-AUTO LIABILITY - CARRIE |
| 8207 | NON-AUTO LIABILITY - PROVIDER |
| 8208 | NON-AUTO LIABILITY - MEMBER |
| 8209 | WORKER'S COMP - CARRIER |
| 8210 | WORKER'S COMP - PROVIDER |
| 8211 | WORKER'S COMP - MEMBER |
| 8212 | PROBATE'S ESTATE |
| 8213 | INCOME PENSION TRUST RECOVERIES |
| 8214 | VICTIM'S RESTITUTION |
| 8215 | ABSENT PARENTS |
| 8216 | TPL ERROR |
| 8217 | DUE TO MISCELLANEOUS OR UNSPECIFIED REASON |
| 8220 | SAVE FOR FUTURE USE * TEMPORARILY USE FOR VOIDS * |
| 8221 | SAVE FOR FUTURE USE. |
| 8222 | SAVE FOR FUTURE USE |
| 8223 | SAVE FOR FUTURE USE. |
| 8224 | SAVE FOR FUTURE USE. |
| 8225 | CAPITATION - DEATH OF MEMBER |

| EOB | DESCRIPTION |
|---|---|
| 8226 | CAPITATION - MEMBER INCARCERATED |
| 8227 | CAPITATION - EPSDT CLAIM |
| 8228 | CAPITATION - MEMBER ENROLLED IN ERROR |
| 8229 | CAPITATION - FAMILY PLANNING |
| 8230 | ICN VOIDED DUE TO WARRANT RETURN. |
| 8231 | CAPITATION - DEMOGRAPHIC CHANGE |
| 8232 | CAPITATION - OTHER |
| 8233 | SAVE FOR FUTURE USE. |
| 8234 | SAVE FOR FUTURE USE. |
| 8240 | ADJUSTMENT GENERATED DUE TO SURS REVIEW |
| 8241 | ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY |
| 8242 | ADJUSTMENT GENERATED DUE TO RATE CHANGE |
| 8244 | PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE |
| 8245 | POINT OF SALE |
| 8246 | POINT OF SALE REVERSAL |
| 8299 | ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS |
| 8300 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED |
| 8301 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXC |
| 8302 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT |
| 8303 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENT |
| 8304 | PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE. |
| 8305 | PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE. |
| 8306 | CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMO |
| 8307 | PAYOUT EXCLUDED FROM CHECKWRITE. |
| 8308 | PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT |
| 8309 | PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT |
| 8310 | PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT |
| 8311 | PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM |
| 8312 | PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT |
| 8313 | PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT |
| 8314 | PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR |
| 8315 | PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR |
| 8316 | PAYOUT DUE TO MANAGED CARE - OTHER |
| 8317 | PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU |
| 8318 | PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR |
| 8319 | PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR |

| EOB | DESCRIPTION |
|---|---|
| 8320 | PAYOUT DUE TO PATIENT LIABILITY ERROR |
| 8321 | PAYOUT DUE TO PATIENT SPENDDOWN ERROR |
| 8322 | PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES |
| 8323 | PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION |
| 8325 | PAYOUT DUE TO GAS SURCHARGE. |
| 8326 | PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED. |
| 8327 | PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT. |
| 8328 | PAYOUT DUE TO DHS/DDSD AUDIT |
| 8329 | PAYOUT PROCESSED FROM STATE ONLY FUNDS |
| 8330 | PAYOUT DUE TO ELIGIBILITY NOT ON FILE. |
| 8331 | PAYOUT DUE TO CLAIM TOO OLD TO PROCESS |
| 8332 | PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON. |
| 8336 | RETROACTIVE INTEREST PAYMENT |
| 8352 | WARRANT VOID-SYSTEM GENERATED |
| 8399 | THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. |
| 8400 | ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED . THE AMOUNT WILL BE DEDUCTED FROM YO |
| 8401 | DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT |
| 8402 | DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WIL |
| 8403 | DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT |
| 8404 | DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED |
| 8405 | DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE |
| 8406 | DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE A |
| 8407 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER |
| 8408 | DECREASE TO ORIGINAL LIEN AMOUNT. |
| 8409 | INCREASE TO ORIGINAL LIEN AMOUNT |
| 8410 | SAVE FOR FUTURE USE |
| 8411 | SAVE FOR FUTURE USE |
| 8412 | SAVE FOR FUTURE USE |
| 8413 | SAVE FOR FUTURE USE |
| 8414 | SAVE FOR FUTURE USE |
| 8415 | SAVE FOR FUTURE USE . |
| 8419 | SAVE FOR FUTURE USE |
| 8420 | AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA |
| 8421 | AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTAB |
| 8422 | AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA |
| 8423 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT. |

| EOB | DESCRIPTION |
|---|---|
| 8424 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE. |
| 8425 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE. |
| 8426 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUS |
| 8427 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE.. |
| 8428 | AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN |
| 8429 | AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHE |
| 8430 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAI |
| 8431 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS. |
| 8432 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD. |
| 8433 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW. |
| 8434 | AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. T |
| 8435 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR. |
| 8436 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR. |
| 8437 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW. |
| 8438 | AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE |
| 8439 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY. |
| 8440 | SAVE FOR FUTURE USE. |
| 8441 | SAVE FOR FUTURE USE. |
| 8442 | SAVE FOR FUTURE USE. |
| 8443 | SAVE FOR FUTURE USE. |
| 8444 | SAVE FOR FUTURE USE. |
| 8445 | SAVE FOR FUTURE USE. |
| 8446 | SAVE FOR FUTURE USE. |
| 8447 | SAVE FOR FUTURE USE. |
| 8448 | SAVE FOR FUTURE USE. |
| 8449 | SAVE FOR FUTURE USE. |
| 8450 | DUE TO A TRANSFER OF ACCOUNT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE |
| 8451 | DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN A |
| 8452 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED |
| 8453 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR |
| 8454 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR |
| 8455 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORREC |
| 8456 | A CASH RECEIPT WAS APPLIED TO AND DECREASED THIS ACCOUNTS RECEIVABLE. |
| 8457 | AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE |
| 8458 | A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE. |
| 8459 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW. |

| EOB | DESCRIPTION |
|---|---|
| 8460 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW |
| 8461 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW. |
| 8462 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW. |
| 8463 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW. |
| 8464 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW. |
| 8465 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED. |
| 8466 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION |
| 8467 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION. |
| 8468 | THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF. |
| 8469 | THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET |
| 8500 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER. |
| 8501 | PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED. |
| 8502 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY. |
| 8510 | CYCLE ACTIVITY |
| 8511 | DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. |
| 8512 | DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED. |
| 8513 | INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. |
| 8514 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER. |
| 8515 | YOUR VOID TRANSACTION HAS BEEN PROCESSED. |
| 8516 | DISCHARGE HOUR MISSING/INVALID |
| 8600 | ZERO CREDIT BALANCE |
| 8601 | PROV REFUND-HEALTH INSUR PAID |
| 8602 | PROV REFUND-RECIPIENT/REL PAID |
| 8603 | PROV REFUND-CASUALTY INSU PAID |
| 8604 | PROV REFUND-PAID WRONG VENDER |
| 8605 | PROV REFUND-APPLY TO ACCT RECV |
| 8606 | PROV REFUND-PROCESSING ERROR |
| 8607 | PROV REFUND-BILLING ERROR |
| 8608 | PROV REFUND-FRAUD |
| 8609 | PROV REFUND-ABUSE |
| 8610 | PROV REFUND-DUPLICATE PAYMENT |
| 8611 | PROV REFUND-COST SETTLEMENT |
| 8612 | PROV REFUND-OTHER/UNKNOWN |
| 8613 | ACCT RECEIVABLE - FRAUD |
| 8614 | ACCT RECEIVABLE - ABUSE |
| 8615 | ACCT RECEIVABLE - TPL |

| EOB | DESCRIPTION |
|---|---|
| 8616 | ACCT RECV - COST SETTLEMENT |
| 8617 | ACCT RECEIVABLE-KYMMIS REQUEST |
| 8618 | RECOUPMENT - WARRANT REFUND |
| 8619 | ACT RECEIVABLE-SURS OTHER |
| 8620 | ACCT RECEIVABLE - DUP PAYT |
| 8621 | RECOUPMENT - FRAUD |
| 8622 | CIVIL MONEY PENALTY |
| 8623 | RECOUPMENT-HEALTH INSUR TPL |
| 8624 | RECOUPMENT-CASUALTY INSUR TPL |
| 8625 | RECOUPMENT-RECIPIENT PAID TPL |
| 8626 | RECOUPMENT - PROCESSING ERROR |
| 8627 | RECOUPMENT - BILLING ERROR |
| 8628 | RECOUPMENT - COST SETTLEMENT |
| 8629 | RECOUPMENT - DUPLICATE PAYMENT |
| 8630 | RECOUPMENT - PAID WRONG VENDOR |
| 8631 | RECOUPMENT - SURS |
| 8632 | PAYOUT-ADVANCE TO BE RECOUPED |
| 8633 | PAYOUT - ERROR ON REFUND |
| 8634 | PAYOUT - RTP |
| 8635 | PAYOUT - COST SETTLEMENT |
| 8636 | PAYOUT - OTHER |
| 8637 | PAYOUT - MEDICARE PAID TPL |
| 8638 | RECOUPMENT - MEDICARE PAID TPL |
| 8639 | RECOUPMENT - DEDCO |
| 8640 | PROVIDER REFUND-OTHER TPL RSN |
| 8641 | ACCT RECV - PATIENT ASSESSMENT |
| 8642 | ACCT RECV - ORTHODONTIC FEE |
| 8643 | ACCT RECEIVABLE - KENPAC |
| 8644 | PARTICIP REQUIREMENTS FAILURE |
| 8645 | ACCT RECEIVABLE - OTHER |
| 8646 | AR CDR HOSP AUDIT |
| 8647 | ACT REC-DEMAND PAYMT UPDT 1099 |
| 8648 | ACT REC-DEMAND PAYMT NO 1099 |
| 8649 | PCG - PART A RECOVERIES |
| 8650 | RECOUPMENT - COLD CHECK |
| 8651 | PROG INTRE POST PAY REV CONT A |

| EOB | DESCRIPTION |
|---|---|
| 8652 | PROG INTRE POST PAY REV CONT B |
| 8653 | CLAIM CREDIT BALANCE |
| 8654 | RECOUPMENT-OTHER ST BRANCH |
| 8655 | RECOUPMENT - OTHER |
| 8656 | RECOUPMENT - TPL CONTRACTOR |
| 8657 | ACCT RECV - ADVANCE PAYMENT |
| 8658 | RECOUPMENT - ADVANCE PAYMENT |
| 8659 | NON CLAIM RELATED OVERAGE |
| 8660 | PROVIDER INITIATED ADJUSTMENT |
| 8661 | PROVIDER INITIATED CLM CREDIT |
| 8662 | CLM CR-PAID MEDICAID VS XOVER |
| 8663 | CLM CR-PAID XOVER VS MEDICAID |
| 8664 | CLM CR-PAID INPATIENT VS OUTP |
| 8665 | CLM CR-PAID OUTPATIENT VS INP |
| 8666 | CLM CREDIT-PROV NUMBER CHANGED |
| 8667 | TPL CLM NOT FOUND ON HISTORY |
| 8668 | FIN CLM NOT FOUND ON HISTORY |
| 8669 | FINANCIAL WITHHOLD PAYMENT |
| 8670 | KENPAC INCENTIVE PAYMENT |
| 8671 | ENC DATA UNACCEPTABLE |
| 8672 | AR OVERAGE LT 99 |
| 8673 | NO MEDICAID/PARTNERSHIP ENROLL |
| 8674 | PROV DATA UNACCEPTABLE |
| 8675 | PCP DATA UNACCEPTABLE |
| 8676 | WITHOLD OTHER |
| 8677 | RECIP INTENTIONAL PGM VIOLATE |
| 8678 | CAP ADJUSTMENT OTHER |
| 8679 | RECIPIENT NOT ELIGIBLE FOR DOS |
| 8680 | ADHOC ADJUSTMENT REQUEST |
| 8681 | ADJ DUE TO SYSTEM CORRECTIONS |
| 8682 | CONVERTED ADJUSTMENT |
| 8683 | MASS ADJ WARR REFUND |
| 8684 | DMS MASS ADJ REQUEST |
| 8685 | MASS ADJ SURS REQUEST |
| 8686 | THIRD PARTY PAID - TPL |
| 8687 | CLAIM ADJUSTMENT - TPL |

| EOB | DESCRIPTION |
|---|---|
| 8688 | BEGINNING DUMMY RECOUPMENT BAL |
| 8689 | ENDING DUMMY RECOUPMENT BAL |
| 8690 | RETRO RATE MASS ADJ |
| 8691 | BEGINNING CREDIT BALANCE |
| 8692 | ENDING CREDIT BALANCE |
| 8693 | BEGINNING DUMMY CREDIT BALANCE |
| 8694 | ENDING DUMMY CREDIT BALANCE |
| 8695 | BEGINNING RECOUPMENT BALANCE |
| 8696 | ENDING RECOUPMENT BALANCE |
| 8697 | BEGIN DUMMY REC BAL |
| 8698 | END DUMMY RECOUP BALANCE |
| 8699 | UNIT DOSE RETURN DRUG ADJ |
| 8700 | PCG 2 PART A RECOVERIES |
| 8701 | PCG 2 PART B RECOVERIES |
| 8702 | PCG 2 AR CDR HOSP |
| 8703 | CONVERTED CLAIM CREDIT BALANCE |
| 8704 | DRG RETRO REVIEW |
| 8705 | DECEASED RECIPIENT RECOUPMENTS |
| 8706 | IMPACT PLUS |
| 8707 | INTEREST RECEIVED |
| 8708 | PROG INTRE POST PAY REV CONT C |
| 8709 | ON DEMAND RECOUPMENT REFUND |
| 8710 | RECOUP PAYOUT |
| 8711 | RECOUPMENT REFUND |
| 8712 | STATE SHARE |
| 8713 | KYMMIS MEDICARE PART A RECOUP |
| 8714 | REG. PSYCH. CROSSOVER REFUND |
| 8998 | CLAIM BEING REVIEWED |
| 8999 | ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95. THIS CLAIM HAS BEEN MANUALLY PRI |
| 9000 | THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE OKLAHOMA HE |
| 9001 | REIMBURSEMENT REDUCED BY THE MEMBER'S CO-PAYMENT AMOUNT. |
| 9002 | ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE |
| 9003 | NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT. |
| 9004 | PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE ALLOWED AMOUNT. |
| 9005 | COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS H |
| 9006 | THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE. |

| EOB | DESCRIPTION |
|---|---|
| 9007 | A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT |
| 9008 | LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. PLEASE RESUBMIT WITH APPROPRIATE |
| 9009 | SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSPITAL CARE LIMITED TO ONCE PER |
| 9010 | SERVICE IS NON-COVERED UNDER THE OKLAHOMA HEALTH COVERAGE PROGRAM |
| 9011 | SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM. |
| 9012 | WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM. |
| 9013 | CLAIM UNDER REVIEW - FOR INTERNAL USE ONLY |
| 9016 | THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DATES |
| 9017 | SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL |
| 9018 | 837 ADJUSTMENT ERROR -- MEMBER MEDICAID ID NOT PRESENT |
| 9019 | 837 ADJUSTMENT ERROR -- CROSSOVER PROVIDER ID NOT PRESENT |
| 9020 | 837 ADJUSTMENT ERROR -- PROVIDER ID NOT PRESENT |
| 9021 | 837 ADJUSTMENT ERROR -- UNABLE TO FIND ORIGINAL ICN |
| 9023 | 837 ADJUSTMENT ERROR -- RECIPIENT NOT FOUND |
| 9024 | 837 ADJUSTMENT ERROR -- PROVIDER NOT FOUND |
| 9025 | 837 ADJUSTMENT ERROR -- ORIGINAL CLAIM NOT FOUND |
| 9026 | 837 ADJUSTMENT ERROR -- CLAIM HAS BEEN ADJUSTED |
| 9027 | 837 ADJUSTMENT ERROR -- CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PROCESS |
| 9030 | CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT P |
| 9031 | GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIM |
| 9036 | ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVI |
| 9040 | REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTR |
| 9075 | CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY COMPLETED. |
| 9080 | NON COVERTED CHARGES |
| 9090 | XOVER W/O MEDICARE SEGMENT FOR REVIEW |
| 9107 | FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN THE AMOUNT PAID FOR COMPONENTS OF THE |
| 9111 | INTERNAL PROCESSING ERROR - CONTACT SE MANAGER |
| 9122 | NO PRICING METHOD ASSIGNED OR UNKNOWN |
| 9175 | CLAIM DENIED. MEMBER'S SIGNATURE AND DATE OF SIGNATURE IN THE MEMBER'S SECTION |
| 9256 | TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF $850.00 PER MONTH, BUT IS N |
| 9257 | MAXIMUM REIMBURSEMENT FOR OXIMETRY IS $280.00 PER 30 DAYS. MAXIMUM REIMBURSEME |
| 9260 | PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIE |
| 9300 | MASS ADJUSTMENT SUSPENDED FOR REVIEW |
| 9302 | INVALID BENEFIT PLAN ON CLAIM |
| 9303 | UNABLE TO ASSIGN PROVIDER CONTRACT |
| 9400 | THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION R |

| EOB | DESCRIPTION |
|---|---|
| 9600 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEM |
| 9601 | REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR ME |
| 9603 | THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBER'S SPENDOWN MET DATE FORTHE |
| 9604 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YE |
| 9605 | HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD |
| 9634 | COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS H |
| 9651 | SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PER |
| 9660 | THIS SERVICE IS NOT PAYABLE, MEMBER IS QMB ALSO AND SPENDDOWN HAS NOT BEEN MET |
| 9661 | POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE |
| 9663 | ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM. |
| 9664 | THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED. |
| 9665 | TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS. |
| 9666 | THE ATTACHMENT TYPE IS NOT VALID. |
| 9700 | THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE |
| 9701 | THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY |
| 9702 | DOLLARS ADJUSTED TO PARAMETER LIMIT |
| 9703 | QTY ADJUSTED TO PARAMETER LIMIT |
| 9704 | COVERED DAYS REDUCED TO ALLOWABLE |
| 9705 | VISITS REDUCED TO AUTHORIZED |
| 9706 | PA CHARGE REDUCED TO AUTHORIZED |
| 9707 | PA UNITS REDUCED TO AUTHORIZED |
| 9708 | THER DAYS REDUCED TO AUTHORIZED |
| 9709 | MAX 14 CONSECUTIVE THER DAYS ALLOWED |
| 9710 | HOSP LEAVE DAYS REDUCED TO AUTHORIZED |
| 9800 | CUTBACK DUE TO HMO PAYMENT/COVERAGE UNDER SOONERCARE PLUS PROGRAM |
| 9900 | REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE |
| 9901 | REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE |
| 9902 | PROCEDURE CODE NOT FOUND ON GROUP |
| 9903 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS |
| 9904 | SERVICE DENIED. REIMBURSEMENT LIMITED TO ONE SET OF LENSES EVERY TWO YEARS FOR |
| 9905 | SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STAT |
| 9906 | PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED |
| 9907 | TPL AMOUNT APPLIED |
| 9908 | PRICING ADJUSTMENT - PHARMACY PRICING APPLIED |
| 9909 | PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED |
| 9910 | PHARMACY DISPENSING FEE APPLIED |

| EOB | DESCRIPTION |
|---|---|
| 9911 | PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED |
| 9912 | PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED |
| 9913 | PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED |
| 9914 | PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED |
| 9915 | PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED |
| 9916 | PRICING ADJUSTMENT - UCC RATE PRICING APPLIED |
| 9917 | PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED |
| 9918 | PRICING ADJUSTMENT - MAX FEE PRICING APPLIED |
| 9919 | PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED |
| 9920 | PRICING ADJUSTMENT - RBRVS PRICING APPLIED |
| 9921 | PRICING ADJUSTMENT - PA PRICING APPLIED |
| 9922 | SPENDDOWN DEDUCTIBLE/PATIENT LIABILITY APPLIED |
| 9923 | SPENDDOWN PATIENT LIABILITY APPLIED |
| 9924 | CLAIM HAS FICA AMOUNT |
| 9925 | CLAIM HAS RECOUPMENT AMOUNT |
| 9926 | CLAIM HAS CUTBACK AMOUNT |
| 9927 | SYSTEM FUND CODE REASSIGNMENT |
| 9930 | REVENUE CODE ZERO PAID WHEN BILLED WITH THIS PROCEDURE CODE. |
| 9931 | PRICING ADJUSTMENT - 100% MEDICARE COINS. & DEDUCT APPLIED |
| 9932 | PRICING ADJUSTMENT - DRG PRICING APPLIED |
| 9933 | PRICING ADJUSTMENT - APC PRICING APPLIED |
| 9935 | PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED |
| 9936 | PRICING ADJUSTMENT - MAX FLAT FEE 2 PRICING APPLIED |
| 9937 | PRICING ADJUSTMENT - UCC FLAT FEE PRICING APPLIED |
| 9938 | PRICING ADJUSTMENT - UCC FLAT FEE 2 PRICING APPLIED |
| 9939 | PRICING ADJUSTMENT - SCHOOL BASED GROUP PRICING APPLIED |
| 9940 | PRICING ADJUSTMENT - PROVIDER PERCENT BILLED APPLIED |
| 9941 | PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED |
| 9942 | PRICING ADJUSTMENT- MEMBER COUNTY PRICING APPLIED. |
| 9943 | PRICING ADJUSTMENT-HOSPICE CROSSWALK PRICING APPLIED. |
| 9944 | PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED |
| 9945 | PRICING ADJUSTMENT - PROVIDER UNIT RATE PRICING APPLIED |
| 9946 | PRICING ADJUSTMENT- PROVIDER SPECIFIC PER DIEM RATES APPLIED |
| 9947 | PRICING ADJUSTMENT - BUNDLED RATE PRICING APPLIED |
| 9948 | OUTPATIENT ASC PRICING APPLIED |
| 9949 | INPATIENT AUTOMATED TRANSPLANT PRICING APPLIED |

| EOB | DESCRIPTION |
|---|---|
| 9950 | PRICING ADJUSTMENT- PPDADD PRICING APPLIED |
| 9951 | PRICING ADJUSTMENT- PROVIDER MAX PER DIEM PRICING APPLIED |
| 9952 | PRICING ADJUSTMENT- REVENUE PCT PRICING APPLIED |
| 9953 | PRICING ADJUSTMENT- ZERO PAID PRICING APPLIED |
| 9954 | KY DEFAULT PERCENTAGE PRICING APPLIED |
| 9955 | PRICING ADJUSTMENT - LESSER ANESTHESIA PRICING APPLIED |
| 9956 | PRICING ADJUSTMENT - NDC PRICING APPLIED |
| 9965 | TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES A QUADRANT. |
| 9970 | PRICING ADJUSTMENT - LT1918 PRICING APPLIED |
| 9971 | PRICING ADJUSTMENT - LTCPTA PRICING APPLIED |
| 9972 | PRICING ADJUSTMENT - LTNQMB PRICING APPLIED |
| 9973 | PRICING ADJUSTMENT - LTPD18 PRICING APPLIED |
| 9975 | PRICING ADJUSTMENT - LTCDME PRICING APPLIED |
| 9991 | REFUND AMOUNT LESS THAN ADJUSTED AMOUNT |
| 9992 | REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT |
| 9995 | ADJUSTMENT DETAIL MANUALLY DENIED |
| 9996 | PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION. |
| 9997 | PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES C |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES. |
| 9999 | PROCESSED PER MEDICAID POLICY |