

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.	395 396	A1	Claim denied charges.	M52	Missing/incomplete/invalid "from" date(s) of service.	OA
0002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE.	275 276 519	A1	Claim denied charges.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).	OA
0003	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE.	397 398	A1	Claim denied charges.	M59	Missing/incomplete/invalid "to" date(s) of service.	OA
0004	MEDICARE PAID DATE IS MISSING OR INVALID.	243	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	OA
0005	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	5276 5277	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.	CO
0007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.	573 3353	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.	OA
0008	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	592	29	The time limit for filing has expired.	MA119	Provider level adjustment for late claim filing applies to this claim.	CO
0009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIM WITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION.	1032 3300	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N26	Missing/incomplete/invalid itemized bill.	CO
0011	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN	594 3345	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.	OA
0012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.	3386	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.	521	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	OA
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.	574	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	OA
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.	217 234	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	M20	Missing/incomplete/invalid HCPCS.	CO

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0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.	572	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	OA
0024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.	268 269	A1	Claim denied charges.	M79	Missing/incomplete/invalid charge.	OA
0026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.	3308	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	N34	Incorrect claim form for this service.	CO
0029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC PROCEDURE CODE AND CRITERIA SET FOR REVIEW.	3384 4014 4813 6000 7236	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	CO
0030	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.	233	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.	CO
0031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.	1018	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO
0036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.	3309	A1	Claim denied charges.	N20	Service not payable with other service rendered on the same date.	OA
0038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.	4162 6073	96	Non-covered charge(s).	M77	Missing/incomplete/invalid place of service.	CO
0039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.	6000 6068 6072	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO
0041	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, MEMBER.	5208	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0044	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID.	339 340	96	Non-covered charge(s).	M50	Missing/incomplete/invalid revenue code(s).	CO
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT	282 283	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	OA
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL.	280 281 3361	A1	Claim denied charges.	M44	Missing/incomplete/invalid condition code.	OA
0052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS.	3311	133	The disposition of this claim/service is pending further review.			OA
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.	509	A1	Claim denied charges.			OA
0055	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED.	508	A1	Claim denied charges.	M54	Missing/incomplete/invalid total charges.	OA
0057	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.	3324 4259 4751	A1	Claim denied charges.	MA30	Missing/incomplete/invalid type of bill.	OA

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0059	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID.	401	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.	CO
0062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.	277	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N46	Missing/incomplete/invalid admission hour.	CO
0063	CLAIM DENIED. AN 8-DIGIT LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FORM LOCATOR #11.	3354	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N77	Missing/incomplete/invalid designated provider number.	CO
0066	PRO STICKER/INDICATOR MISSING OR INVALID	3336 3366	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
0067	FAMILY PLANNING INDICATOR INVALID.	3302	A1	Claim denied charges.	M49	Missing/incomplete/invalid value code(s) or amount(s).	OA
0070	TIME OF PICK UP IS MISSING OR INVALID.	3303	A1	Claim denied charges.			OA
0073	REFERRED TO 'OTHER' CODE INVALID.	3312	A1	Claim denied charges.	M49	Missing/incomplete/invalid value code(s) or amount(s).	OA
0074	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT.	3352	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M2	Not paid separately when the patient is an inpatient.	CO
0078	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.	3344 5411 5412 5413 5414	A1	Claim denied charges.	M51	Missing/incomplete/invalid procedure code(s) and/or rates.	OA
0083	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID	367 368	A1	Claim denied charges.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).	OA
0084	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.	364 365 529	A1	Claim denied charges.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).	OA
0087	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.	514	110	BILLING DATE PREDATES SERVICE DATE.	M59	Missing/incomplete/invalid "to" date(s) of service.	CO
0088	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.	259 506	A1	Claim denied charges.	MA52	Missing/incomplete/invalid date.	OA
0100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID.	220 264 265 527	A1	Claim denied charges.	M52	Missing/incomplete/invalid "from" date(s) of service.	OA
0101	DETAIL TO DATE OF SERVICE MISSING OR INVALID.	239 240 507 3322	A1	Claim denied charges.	M59	Missing/incomplete/invalid "to" date(s) of service.	OA
0102	CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. VERIFIES THAT EACH DETAIL OF A CLAIM IS RECEIVED WITHIN 1 YEAR FROM THE DATE OF	512 545 555 556	29	The time limit for filing has expired.	MA119	Provider level adjustment for late claim filing applies to this claim.	CO
0110	CLAIM SUSPENDED FOR REVIEW.	3323 3331	133	The disposition of this claim/service is pending further review.	MA07	The claim information has also been forwarded to Medicaid for review.	OA
0113	CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE.	6128 6135	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	CO
0117	CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM.	3318	A1	Claim denied charges.			OA

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0121	THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY MEMBER	4314 4371 4374 4376 4886	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDI CAID WITH A COPY OF THE MEDICARE EOMB.	3317	A1	Claim denied charges.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	OA
0123	CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY. PLEASE REFER T O THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL.	3372	6	The procedure code is inconsistent with the patient's age.	N30	Recipient ineligible for this service.	CO
0124	CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR MEMBERS AGE 22 THROU GH 64.	3388	6	The procedure code is inconsistent with the patient's age.	N30	Recipient ineligible for this service.	CO
0125	THE TOOTH NUMBER IS MISSING OR INVALID.	261 262	A1	Claim denied charges.	N37	Missing/incomplete/invalid tooth number/letter.	OA
0127	CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID.	263	A1	Claim denied charges.	N75	Missing/incomplete/invalid tooth surface information.	OA
0130	CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXC EDED.	6001 6137 6138 6139 6144	119	Benefit maximum for this time period has been reached.			CO
0131	CLAIM/DETAIL DENIED. CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY.	6002	119	Benefit maximum for this time period has been reached.			CO
0136	PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE.	248 249 3346	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service.	CO
0137	CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHA RGES.	3392 5293 5299 5400	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.			CO
0138	CLAIM DENIED. LOCK-IN MEMBER.	2603	38	Services not provided or authorized by designated (network) providers.	N30	Recipient ineligible for this service.	CO
0139	CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PE R MEMBER.	6003	119	Benefit maximum for this time period has been reached.			CO
0145	THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY.	4212	A1	Claim denied charges.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office	OA
0146	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE.	4141 4150 4151 4152	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	CO
0148	THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE.	4036 4821	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N79	Service billed is not compatible with patient location information.	CO
0149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBER'S AGE.	3364 4025	6	The procedure code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0150	THIS PROCEDURE IS INVALID FOR THE MEMBER'S SEX.	3385 4035 4962 4963 4964	7	The procedure code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0151	CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE	4013 4077 4347 4383 4803	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO

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0152	PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY KENTUCKY MEDICAID.	235 4004 4032 4059	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	CO
0153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	4315 4731 4733 4736 4745 4746	11	The diagnosis is inconsistent with the procedure.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0154	PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER.	6021	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD.	1008	A1	Claim denied charges.	N55	Procedures for billing with group/referring/performing providers were not followed.	OA
0156	THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER.	4014	A1	Claim denied charges.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of	OA
0157	PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY.	4149	B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0162	CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY.	4316	96	Non-covered charge(s).			CO
0163	CLAIM DETAIL DENIED. EMPLOYEE ID/PERSONAL IDENTIFIER MISSING OR INVALID.	3304	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M57	Missing/incomplete/invalid provider identifier.	CO
0164	PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.	4053	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.	OA
0165	SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.	4054	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	OA
0166	CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBER'S AGE.	4063 4064	6	The procedure code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX.	4064	7	The procedure code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0170	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.	4067	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.	OA
0171	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.	4055	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	OA
0172	SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	4318	11	The diagnosis is inconsistent with the procedure.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0181	RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED.	3372	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N3	Missing/incomplete/invalid consent form.	CO

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0182	RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE.	4012 4022 4065	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M29	Missing/incomplete/invalid operative report.	CO
0190	THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	272 4040	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0191	THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	242 4041	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.	CO
0192	THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE.	4030 4711	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0196	THE BILLED DIAGNOSIS IS ON REVIEW.	4311 4812	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH.	2057	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	OA
0199	CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999).	4196 4393	A1	Claim denied charges.			OA
0201	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.	201 3382	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE	4776	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.	CO
0206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.	1002	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO
0211	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE.	4042	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.	CO
0212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.	224 459	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO
0213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	4043	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.	CO
0220	SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	3328	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.	CO
0221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE.	1048	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO
0223	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE	1049	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO
0226	CANNOT BE PROCESSED ON THIS CLAIM FORM.	4871 4873 4874	A1	Claim denied charges.	N34	Incorrect claim form for this service.	OA
0228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE.	802	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO

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0229	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE.	202 803 1000 9019	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M57	Missing/incomplete/invalid provider identifier.	CO
0230	THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE.	804	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.	CO
0232	CLAIM/DETAIL DENIED. ACTION REASON CODE INDICATES PROVIDER IS ON REVIEW.	7500 7509	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N35	Program integrity/utilization review decision.	CO
0237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE.	805	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	M57	Missing/incomplete/invalid provider identifier.	OA
0238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.	806	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.	CO
0242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26.	4209	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
0245	THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER.	2800 3600 4017 4970	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N32	Provider performing service must submit claim.	CO
0250	THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER.	810	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.	CO
0252	MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DAT ABASE FOR THE MAID NUMBER SUBMITTED ON YOUR CLAIM.	513	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.	CO
0254	THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES.	811	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.	CO
0257	OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE MEMBER IS NOT ELIGIBLE FOR THE SERVICE(S).	4714	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS MEMBER. MEDICAID CLAIMS ARE NOT REIMBURSIBLE FOR THIS M	4021 4227 4244 4765 4882	96	Non-covered charge(s).	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	CO
0262	MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE.	812	A1	Claim denied charges.	N30	Recipient ineligible for this service.	OA
0263	CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE.	813	A1	Claim denied charges.	N30	Recipient ineligible for this service.	OA
0264	MEMBER NAME IS MISSING.	238	31	Claim denied as patient cannot be identified as our insured.	MA36	Missing/incomplete/invalid patient name.	CO
0265	INCORRECT MEMBER IDENTIFICATION NUMBER.	203	31	Claim denied as patient cannot be identified as our insured.			CO
0266	MEMBER NOT ELIGIBLE FOR WAIVER SERVICES.	3600 4140 4142	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO

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0267	WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME	3306	142	Claim adjusted by the monthly Medicaid patient liability amount.			PR
0268	MEMBER ON REVIEW	2043	140	Patient/Insured health identification number and name do not match.			CO
0271	CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE CONTACT DMS AT 502-564-6885.	800 3305	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N58	Missing/incomplete/invalid patient liability amount.	CO
0272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN	3347	42	Charges exceed our fee schedule or maximum allowable amount.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN	3347	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0276	DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATION MEMBERS.	3365	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY MEMBER.	278	100	Payment made to patient/insured/responsible party.	MA92	Missing/incomplete/invalid primary insurance information.	OA
0279	CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTER ED ON CLAIM.	3356	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92	Missing/incomplete/invalid primary insurance information.	CO
0280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST.	451 3357	19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers Compensation Carrier.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	OA
0282	THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE.	2500 2501	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	CO
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE.	2502 2503 2509 2514	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	CO
0284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST.	3351	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	CO
0286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE.	3387 4020	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.	231 232 1007	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M57	Missing/incomplete/invalid provider identifier.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0294	KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMARY PHYSICIAN/CLINIC NUMBER FOR THE DATE(S) OF SERVICE.	226 1050	38	Services not provided or authorized by designated (network) providers.	M68	Missing/incomplete/invalid attending or referring physician identification.	CO
0297	MEMBER IS NOT ELIGIBLE FOR HOSPICE.	815	28	Coverage not in effect at the time the service was provided.	N30	Recipient ineligible for this service.	CO
0298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE.	816 4021 4227	28	Coverage not in effect at the time the service was provided.	N30	Recipient ineligible for this service.	CO
0299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE.	801 2602	B9	Services not covered because the patient is enrolled in a Hospice.	N30	Recipient ineligible for this service.	CO
0304	OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVAL.	5274	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N20	Service not payable with other service rendered on the same date.	OA
0310	CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE.	3360	96	Non-covered charge(s).	MA41	Missing/incomplete/invalid admission type.	CO
0321	EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES.	5241	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0334	SUPPLY NOT COVERED ON RENTAL ITEM.	5209	96	Non-covered charge(s).			CO
0337	CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROVIDER.	5211	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS.	5243	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE OF SERVICE AS EMERGENCY SERVICES OR SEALANTS.	5213	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0354	MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB	3321	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
0359	REFER TO THE ADJUSTMENT REASON CODE.	3338 4005	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim.	OA
0363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION	5245	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0368	REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER.	3310	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of	CO
0369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE.	5238	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE.	5280	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.	3370	42	Charges exceed our fee schedule or maximum allowable amount.			CO
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.	3370	45	Charges exceed your contracted/ legislated fee arrangement.			CO
0379	PAID BY MEDICAID	5102	42	Charges exceed our fee schedule or maximum allowable amount.	MA125	Per legislation governing this program, payment constitutes payment in full.	CO
0379	PAID BY MEDICAID	5102	45	Charges exceed your contracted/ legislated fee arrangement.	MA125	Per legislation governing this program, payment constitutes payment in full.	CO
0381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT	5282	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY.	5215 5216 5247	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE.	5248	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO NON-COVERED.	3307	96	Non-covered charge(s).	M50	Missing/incomplete/invalid revenue code(s).	CO
0392	DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091.	5218	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES.	5220	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM.	4225	5	The procedure code/bill type is inconsistent with the place of service.			CO
0398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	4161	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS PE MEMBER.	4017 4021 4227 4244 4765 4882	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.	1032 1036	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	N34	Incorrect claim form for this service.	OA
0412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.	3320	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.	CO
0414	MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.	2017 4021 4227 4244 4765 4882	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	N30	Recipient ineligible for this service.	OA
0426	THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE	6736 6756	A1	Claim denied charges.			OA
0436	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS.	6136	119	Benefit maximum for this time period has been reached.			CO
0436	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS.	6136	A1	Claim denied charges.			OA
0437	CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAY S PRIOR TO AN INPATIENT HOSPITAL ADMISSION (AND VICE VERSA).	5628 5629 5630 5631 5635 5636 5637 5638 5639 5640 5641 5642	97	Payment is included in the allowance for another service/procedure.			OA
0438	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER M EMBER, PER PROVIDER.	6004 6005	A1	Claim denied charges.			OA
0439	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER CALENDAR WEEK, PER MEMBER, PER PROVIDER.	6006	A1	Claim denied charges.			OA
0440	CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SU NDAY THROUGH SATURDAY).	6007	119	Benefit maximum for this time period has been reached.			CO
0441	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER MEMBER.	6008	97	Payment is included in the allowance for another service/procedure.			OA
0442	CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME DATE OF S ERVICE AS PROCEDURE CODES 99244 AND 99245.	5251	97	Payment is included in the allowance for another service/procedure.			OA
0445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PE R MEMBER, PER PROVIDER.	6009	119	Benefit maximum for this time period has been reached.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.	6010	119	Benefit maximum for this time period has been reached.			CO
0447	CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY.	6160	119	Benefit maximum for this time period has been reached.			CO
0452	CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK.	6011	119	Benefit maximum for this time period has been reached.			CO
0453	CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY.	6012	119	Benefit maximum for this time period has been reached.			CO
0454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.	6013	119	Benefit maximum for this time period has been reached.			CO
0455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.	6014	119	Benefit maximum for this time period has been reached.			CO
0456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	6015	119	Benefit maximum for this time period has been reached.			CO
0457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY.	6016	119	Benefit maximum for this time period has been reached.			CO
0458	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY.	6017	119	Benefit maximum for this time period has been reached.			CO
0460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	6018	119	Benefit maximum for this time period has been reached.			CO
0461	CLAIM/DETAIL DENIED. XL307/97535 LIMITED TO 80 UNITS PER WEEK.	6019	119	Benefit maximum for this time period has been reached.			CO
0465	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT).	2504	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	CO
0466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER.	5287	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.	2504 4316	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary	CO
0469	CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK.	6298	119	Benefit maximum for this time period has been reached.			CO
0473	MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO.	5017	119	Benefit maximum for this time period has been reached.	MA125	Per legislation governing this program, payment constitutes payment in full.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.	5609 5615 5617 5618 5619 5620	18	Duplicate claim/service.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	CO
0479	CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER.	5613	18	Duplicate claim/service.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	5001 5015 5603 5604	18	Duplicate claim/service.			CO
0483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST.	5014	18	Duplicate claim/service.			CO
0487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS.	4316	11	The diagnosis is inconsistent with the procedure.			CO
0489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.	5601	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.	5231 5625	60	Charges for outpatient services with this proximity to inpatient services are not covered.	N47	Claim conflicts with another inpatient stay.	CO
0491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.	5614 5621 5622 5623	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	CO
0496	ONLY ONE (1) ANESTHESIA/IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER.	5225	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0502	ONE FAMILY PLANNING SERVICE PER DOS.	6131	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0504	FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD.	6126	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0505	MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE.	5608 5624 5633 5634	18	Duplicate claim/service.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	CO
0508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS.	5203	97	Payment is included in the allowance for another service/procedure.	M71	Total payment reduced due to overlap of tests billed.	OA
0511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE.	5205	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.	5206	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0513	CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION.	5239	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0515	CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.	5207	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED.	5240	18	Duplicate claim/service.			CO
0517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER .	6121	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED.	5283	18	Duplicate claim/service.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0537	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	5253	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS.	6021	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0544	CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS.	6022	A1	Claim denied charges.			OA
0545	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	5602 5616	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	M79	Missing/incomplete/invalid charge.	CO
0548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185.	5226	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	M50	Missing/incomplete/invalid revenue code(s).	CO
0549	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	5227 6757 6758	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0550	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.	5228	A1	Claim denied charges.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY.	5288	97	Payment is included in the allowance for another service/procedure.			OA
0552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY.	809	119	Benefit maximum for this time period has been reached.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT.	557	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	OA
0556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY.	5254	60	Charges for outpatient services with this proximity to inpatient services are not covered.	M2	Not paid separately when the patient is an inpatient.	CO
0558	CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY.	6024	A1	Claim denied charges.			OA
0567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.	3306	A1	Claim denied charges.	N58	Missing/incomplete/invalid patient liability amount.	OA
0576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185.	3355	60	Charges for outpatient services with this proximity to inpatient services are not covered.	M50	Missing/incomplete/invalid revenue code(s).	CO
0577	CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BIL LED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER BY THE SAME OR DIFFERENTPRO	5229	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALEN DAR WEEK (SUNDAY THROUGH SATURDAY).	6028	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF \$1000.00 PER MEMBER FOR MINOR HO ME ADAPTATIONS HAS BEEN EXCEEDED.	6029	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF EIGHT UNITS PER MEMBER, PER PREGNANCY.	6030	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF 76 UNITS PER MEMBER, PER PREGNANCY.	6031	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0583	CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COM BINED TOTAL OF 108 UNITS PER MEMBER, PER PREGNANCY.	6032	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0584	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	6033	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE C ODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER MEMBER, PER DAY.	6034 6186	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0586	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 (6035 6187	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBI NED TOTAL OF 8 UNITS PER MEMBER, PER DAY.	6036	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0588	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).	6037 6303	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0589	CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILL ED IN CONJUNCTION WITH SUBSTANCE ABUSE CASE MANAGEMENT (DATES OF SERVICE WITHIN	5230	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0591	CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCED URE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS INTENSIVE OUTPATIENT S	5289	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0593	CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH W B505, WB516, WB526/90862(UD), WB507, WB521, WB602/90804(UD), WB508, WB522, WB60	5255	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURG ICAL PROCEDURE.	5500	97	Payment is included in the allowance for another service/procedure.	N19	Procedure code incidental to primary procedure.	OA
0597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.	5256	97	Payment is included in the allowance for another service/procedure.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	OA
0598	CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE.	6041 6213	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS.	6042	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS	6043	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER.	6044	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0604	NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SAME DATE OF SERVICE.	6045	A1	Claim denied charges.	N19	Procedure code incidental to primary procedure.	OA
0605	ONLY FOUR PSYCHIATRIC PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER.	6046 6190	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0606	PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER.	5257	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0607	EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER.	6048	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0608	CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER CALENDAR MONTH.	6074 6109	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0609	CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONTH PERIOD.	6733	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0610	CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS.	6050	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0617	MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS.	6056	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0618	ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS.	6057	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0619	MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR.	6058	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0621	DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED.	6084 6140 6747	45	Charges exceed your contracted/legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0622	DETAIL DENIED. ANNUAL LIMIT OF \$500.00 FOR MINOR HOME ADAPTIONS.	6060	45	Charges exceed your contracted/legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0623	MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER.	6061	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DENTIST PER TOOTH PER PROVIDER.	5232 6201 6202 6204 6301 6302	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS.	6065	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0627	CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS.	6064	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0629	MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS.	6067	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0631	MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS.	6069	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY.	6705	A1	Claim denied charges.			OA
0636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGASSES ALLOW ONE / 12 MOS / MEMBER.	6071	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL.	807	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
0642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER.	6077	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0644	MEMBERS ARE LIMITED TO ONE (1) OPHTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS.	6078	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0645	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.	6079	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS.	5101 6078 6080	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0648	MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS .	6059	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0650	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT.	6119	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTH S.	6122	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER .	6020	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.	6023	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.	6025	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER .	6026	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.	6062	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0660	MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR.	6063	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0661	CLAIM DENIED. READMISSION WITHIN 14 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH DOCUMENTATION NECESSITATING READMISSION ALONG WITH BOTH DIS	5626	119	Benefit maximum for this time period has been reached.	N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	CO
0665	VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLO WED SAME DOS/MEMBER/PROVIDER.	6070	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.	CO
0666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-M ICROSCOPY LAB CODE.	4208	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	CO
0667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE.	6102 6103 6110	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0668	DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SE RVICE.	6066	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M139	Denied services exceed the coverage limit for the demonstration.	OA
0670	DAYS REDUCED, A MAXIMUM OF 15 NON HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER,PER CALENDAR YEAR.	5627	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY.	6127	119	Benefit maximum for this time period has been reached.			CO
0673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.	389 4393	A1	Claim denied charges.			OA
0674	PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS .	6027	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0675	CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, P ER PROVIDER, PER 60 DAYS.	6075	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0676	PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090.	5233	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS.	6076	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE.	6081	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE.	6111	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0683	MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES P ER DATE OF SERVICE.	6104	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE.	6128	A1	Claim denied charges.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE D AYS PER MEMBER.	6082	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR M ONTH, PER MEMBER.	6083	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0696	CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-150 0.	3367	A1	Claim denied charges.	N200	The professional component must be billed separately.	OA
0699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$260.00 IN	5103 5104 5105	A1	Claim denied charges.			OA
0701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIAT RIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER MEMBERIE	6086	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER.	6038	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER MEMBER, PER PROVIDER.	6039	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER MEMBER, PER PROVIDER.	6112	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.	CO
0705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	6087	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO VIDER, PER 36 MONTHS/THREE YEARS.	6120	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	6123	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, P ER 36 MONTHS/THREE YEARS.	6124	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

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0709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER.	6040	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0710	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	5261 5291	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER MEMBER PER DATE OF SERVICE.	6088 6090 6091 6105 6108 6125 6132 6145 6148	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0718	CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PRO VIDER, PER MEMBER, PER CALENDAR MONTH.	6089	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0719	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER MEMBER, PER CALENDAR YEAR.	6113	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0722	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	5606	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER , PER DATE OF SERVICE, PER TOOTH NUMBER.	6299	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0724	CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO \$1000.00 IN PAYMENTS PER SIX MONTHS.	6092	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0725	INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY,PER MEMBER,P ER PROVIDER.	6106	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVID ER, EVERY TWO YEARS.	6093	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFE TIME.	6047	35	Benefit maximum has been reached.			CO
0729	PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLA R PER LIFETIME.	6094	35	Benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0730	PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER.	6095	35	Benefit maximum has been reached.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0731	MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS.	6096	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0732	ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT, PER MEMBER, PER LIFETIME.	6114	35	Benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0733	PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EACH PER QUADRANT, PER MEMBER, PER 12 MONTH PERIOD, PER PROVIDER.	6115	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0734	CLAIM/DETAIL DENIED. PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT.	5611	97	Payment is included in the allowance for another service/procedure.	N81	Procedure billed is not compatible with tooth surface code.	OA
0736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PROVIDER, PER DATE OF SERVICE.	6049 6759	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0737	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER MEMBER.	6051	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0738	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER.	6052	35	Benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0739	CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING.	5258	97	Payment is included in the allowance for another service/procedure.	N81	Procedure billed is not compatible with tooth surface code.	OA
0741	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICAL NECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATED	6129 6731 6735	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0742	DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 12 MONTHS.	6097	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0743	GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVIDER.	6098	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.	CO
0744	CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF SERVICE. PLEASE CHECK THE UNITS OF SERVICE BILLED FOR ERRORS	6130	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO
0747	CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS PER SEVEN DAY PERIOD.	6116	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE.	4748	5	The procedure code/bill type is inconsistent with the place of service.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0749	CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS.	6099	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE.	7000 7001	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).	CO
0752	REVENUE CODE MISSING/INVALID.	4059	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).	CO
0781	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT	6706 6707 6708 6709 6710 6711	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0782	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT	6712 6713 6714 6715	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR	5298	A1	Claim denied charges.			OA
0785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER	6716	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0786	CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER	6751	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0788	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER	6717	A1	Claim denied charges.			OA
0789	CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8)	6718	A1	Claim denied charges.			OA
0790	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER	6719	A1	Claim denied charges.			OA
0791	CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY).	6053	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD.	6117	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.	6085 6100	119	Benefit maximum for this time period has been reached.			CO
0794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER MEMBER.	6118 6300	119	Benefit maximum for this time period has been reached.			CO
0795	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	6134 6185 6191 6192 6193 6194 6197 6199 6203 6206 6207 6215 6240 6241 6242 6243 6245 6246 6290 6291 6292 6293 6294 6295 6296 6739 6740 6741	119	Benefit maximum for this time period has been reached.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
0796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	6133 6163 6164 6165 6166 6167 6170 6172 6173 6174 6177 6182 6183 6184 6732	119	Benefit maximum for this time period has been reached.			CO
0799	REVENUE CODE 270 CANNOT EXCEED \$2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH.	6054	45	Charges exceed your contracted/ legislated fee arrangement.	M54	Missing/incomplete/invalid total charges.	CO
0801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X 0074 OR X0075.	5234	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0802	PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE SAME DATE OF SERVICE AS PROCEDURES 09110/D9110 OR 00140/D0140.	5259	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN BILLING FOR SUTURE OF WOUND.	5294	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0814	MEMBER ID NUMBER IS INVALID.	814 5262	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROCEDURES, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROCEDURES TO THE DMS FOR R	5264	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0820	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	5296	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	M68	Missing/incomplete/invalid attending or referring physician identification.	OA
0821	CLAIM DETAIL DENIED. LIMITATION EXCEEDED.	6055 6208 6209	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.			CO
0822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES.	5266	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0825	DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER.	5268	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.	OA
0830	CLAIM DENIED. NO DRG FOUND.	4099	147	Provider contracted/negotiated rate expired or not on file.			CO
0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.	4384 4721 4781	A8	Claim denied; ungroupable DRG	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0832	CLAIM DENIED. DRG CRITERIA NOT MET.	4134	A8	Claim denied; ungroupable DRG			CO

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0833	CLAIM DENIED. DRG INVALID AGE.	4388 4384	A8	Claim denied; ungroupable DRG			CO
0834	CLAIM DENIED. DRG INVALID SEX.	4389	A8	Claim denied; ungroupable DRG			CO
0835	CLAIM DENIED. DRG INVALID DISCHARGE STATUS.	3332 4390	A8	Claim denied; ungroupable DRG	N50	Missing/incomplete/invalid discharge information.	CO
0836	CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS.	4722	A8	Claim denied; ungroupable DRG	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0838	PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER	6720	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0839	RESERVED FOR DRG	6752	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0840	PROCEDURE CODE HAS BEEN REBUNDLED.	7217 7218	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
0842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE.	7219	96	Non-covered charge(s).	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0843	PROCEDURE CODE IS INCIDENTAL.	7215	96	Non-covered charge(s).	N19	Procedure code incidental to primary procedure.	CO
0844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT.	7216	97	Payment is included in the allowance for another service/procedure.	N19	Procedure code incidental to primary procedure.	OA
0845	VISIT IS WITHIN ONE DAY PRE OP RANGE.	7220	97	Payment is included in the allowance for another service/procedure.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE	7233 7235 7236 7237 7238 7239	97	Payment is included in the allowance for another service/procedure.			OA
0847	PROCEDURE IS A BILATERAL OR DUPLICATE	7234	18	Duplicate claim/service.			CO
0849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON.	7222	54	Multiple physicians/assistants are not covered in this case .			OA
0850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE.	7201 7202 7203 7204 7211 7212	6	The procedure code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0852	GMIS - INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE.	7201 7202 7203 7211 7212	6	The procedure code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0856	PROCEDURE NOT INDICATED FOR A MALE	7205 7213 7214	7	The procedure code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0857	PROCEDURE NOT INDICATED FOR A FEMALE	7206	7	The procedure code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0858	CLAIM DENIED. COSMETIC PROCEDURE.	7207	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.			CO
0859	CLAIM DENIED. DUPLICATE PROCEDURE.	7235 7237 7238	18	Duplicate claim/service.			CO
0860	CLAIM DENIED. EXPERIMENTAL PROCEDURE.	7209	96	Non-covered charge(s).			CO
0861	CLAIM DENIED. OBSOLETE PROCEDURE.	7210	96	Non-covered charge(s).	MA66	Missing/incomplete/invalid principal procedure code or date.	CO
0863	PROCEDURE CODES DOES NOT REQUIRE AN ASSISTANT SURGEON	7223	54	Multiple physicians/assistants are not covered in this case .			OA
0868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS LIMITED TO ONE PER FOUR YEARS.	6721	A1	Claim denied charges.			OA
0873	CLAIM/DETAIL DENIED. EYEWEAR LIMITATION OF \$400.00 PER CALENDAR YEAR HAS	6722	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO

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0874	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF \$200.00 PER CALENDAR YEAR HAS	6723	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0875	CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF \$1500.00 PER	6724	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO \$800.00 PER EAR, PER	6737 6738	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0877	CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE	6725	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0878	CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS	6727	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO
0886	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE BILLED.	7208	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	CO
0888	GMIS-VISIT IS WITHIN THE POST OP RANGE.	7221	97	Payment is included in the allowance for another service/procedure.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	OA
0889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE.	3381	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.	CO
0890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES.	3380 4157	11	The diagnosis is inconsistent with the procedure.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0891	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE DIAGNOSIS CODES.	3379	11	The diagnosis is inconsistent with the procedure.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM.	219 220	A1	Claim denied charges.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	OA
0902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES.	220	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.	OA
0908	CLAIM/DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE.	3363	60	Charges for outpatient services with this proximity to inpatient services are not covered.	MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.	CO
0909	CLAIM/DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.	1030	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
0910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.	808	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO

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0913	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED.	3358	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.	OA
0915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.	3329 3330	42	Charges exceed our fee schedule or maximum allowable amount.	M54	Missing/incomplete/invalid total charges.	CO
0915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.	3329 3330	45	Charges exceed your contracted/legislated fee arrangement.	M54	Missing/incomplete/invalid total charges.	CO
0916	EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS MEMBER.	4140	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE.	3327	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	OA
0919	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 21ST BIRTHDAY.	4034	6	The procedure code is inconsistent with the patient's age.			CO
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE.	3326	42	Charges exceed our fee schedule or maximum allowable amount.	N48	Claim information does not agree with information received from other insurance carrier.	CO
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE.	3326	45	Charges exceed your contracted/legislated fee arrangement.	N48	Claim information does not agree with information received from other insurance carrier.	CO
0923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENT'S ACCOUNT NUMBER FIELD ON THE CLAIM.	3333	A1	Claim denied charges.	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient	OA
0924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6TH BIRTHDAY MUST BE SPLIT BILLED. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR	3315 3383 3391	A1	Claim denied charges.	N59	Please refer to your provider manual for additional program and provider information.	OA
0929	CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE.	6107	A1	Claim denied charges.			OA
0930	CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE.	3341 3342	A1	Claim denied charges.			OA

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0932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR	6728	A1	Claim denied charges.			OA
0936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE.	5610	A1	Claim denied charges.			OA
0938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED	6729	A1	Claim denied charges.			OA
0939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER	6730	A1	Claim denied charges.			OA
0942	CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE.	3334	A1	Claim denied charges.			OA
0950	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY MEMBERS.	4021	96	Non-covered charge(s).	N30	Recipient ineligible for this service.	CO
0953	CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER.	3343	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	4248	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.	CO
0961	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.	1030 3359	97	Payment is included in the allowance for another service/procedure.	M50	Missing/incomplete/invalid revenue code(s).	OA
0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 21.	3389 4715	6	The procedure code is inconsistent with the patient's age.			CO
0967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY.	3314	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO
0968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY.	3319	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.	CO
0969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD.	4120	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	OA
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD.	4392	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	OA
0972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY.	3393	A1	Claim denied charges.	M51	Missing/incomplete/invalid procedure code(s) and/or rates.	OA
0973	PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DETAIL.	6101	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO

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0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCEDURE GINGIVECTOMY PROCEDURE .	602	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.	OA
0977	TYPE OF BILL INVALID FOR PROVIDER TYPE.	3368	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	MA30	Missing/incomplete/invalid type of bill.	OA
0978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.	5202	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	OA
0981	CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR CERTAIN PROCEDURE CODES, FOR DATES OF SERVICE AFTER 11/30/02. PLEASE VERIFY OUR	3335	A1	Claim denied charges.	M117	Not covered unless supplier files an electronic media claim (EMC).	OA
0984	MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE .	451 558	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N48	Claim information does not agree with information received from other insurance carrier.	CO
0985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.	3390	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO
0986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE.	3348	107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP.	3349	119	Benefit maximum for this time period has been reached.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
0988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS.	3350	A1	Claim denied charges.	M54	Missing/incomplete/invalid total charges.	OA
0989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.	3337	96	Non-covered charge(s).	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	CO
0990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRTHDAY.	4714	6	The procedure code is inconsistent with the patient's age.			CO
0993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE.	5416	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.	OA
0996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID.	3339	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.	OA
1001	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER).	1001	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
1006	FACILITY PROVIDER NOT ELIGIBLE AT SERVICE LOCATION FOR PROGRAM BILLED	1006	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA

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1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP.	1010	38	Services not provided or authorized by designated (network) providers.			CO
1016	NON-PARTICIPATING MANUFACTURER	1016	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1037	FACILITY PROVIDER I.D. NOT ON FILE	1037	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
1052	TAXONOMY CODE INVALID FOR RENDERING PROVIDER	1052 1056 1057	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1053	TAXONOMY CODE INVALID FOR PERFORMING PROVIDER	1053 1056 1057	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1054	TAXONOMY CODE INVALID FOR BILLING PROVIDER	1056	45	Charges exceed your contracted/ legislated fee arrangement.			CO
1055	DTL REFERRING PROV NOT ON FILE	1055	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM	1058	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N77	Missing/incomplete/invalid designated provider number.	CO
1060	NO RENDERING PROVIDER FOR CROSSOVER CLAIM	1060	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
1061	NO FACILITY PROVIDER FOR CROSSOVER CLAIM	1061	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
1118	THIS DRUG NOT COVERED BY MEDICARE PART D	4999	96	Non-covered charge(s).			CO
1606	MISSING OR INVALID PAYER DATE	606	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1643	INVALID OTHER COVERAGE CODE	643	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO

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1652	MISSING OR INVALID OTHER PAYER COVERAGE TYPE	652	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
1950	PROCEDURE INCLUDED IN BUNDLED RATE	1950	B15	Payment adjusted because this procedure/service is not paid separately.			OA
1951	HCPC IS REQUIRED	1951	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M20	Missing/incomplete/invalid HCPCS.	CO
1956	CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE REFERRING PROVIDER.	1956	129	Payment denied - Prior processing information appears incorrect.	N287	Missing/incomplete/invalid referring provider secondary identifier.	OA
1995	MMIS FACILITY PROVIDER ID NOT ENROLLED	1995	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM.	1996	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO
1997	THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICA ID SYSTEM. PLEASE BILL FUTURE CLAIMS WITH THE PROVIDER NUMBER ASSIGNED DURING	1997	45	Charges exceed your contracted/ legislated fee arrangement.	M57	Missing/incomplete/invalid provider identifier.	CO
1999	BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT	1999	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
2000	ERROR DISPOSITION SETUP IS INVALID	383 384 6734	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2001	MEMBER ID NUMBER NOT ON FILE.	2001	119	Benefit maximum for this time period has been reached.	N382	Missing/incomplete/invalid patient identifier.	CO
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE.	2002 5100	119	Benefit maximum for this time period has been reached.			CO
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE.	2003	35	Benefit maximum has been reached.			CO
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE.	6151 6153 6154 6155 6156 6157 6158 6159 6161 6175 6260 6374 6445 6459 6460 6469 6470 6476	35	Benefit maximum has been reached.			CO
2004	PROCEDURE INCLUDED IN COMBINED PROCEDURE	6149 6150	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	OA
2005	PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH	6550	119	Benefit maximum for this time period has been reached.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2006	RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA	6551	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.			CO
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE	6162	119	Benefit maximum for this time period has been reached.			CO
2009	MEMBER INELIGIBLE ON DATE OF SERVICE.	2009	119	Benefit maximum for this time period has been reached.			CO
2010	PRESCRIPTION REFILLED TOO SOON	5109	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.			CO
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED	6471 6472 6473 6474 6475	35	Benefit maximum has been reached.			CO
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED	6482 6508 6509	119	Benefit maximum for this time period has been reached.			CO
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR	6261 6490 6491	35	Benefit maximum has been reached.			CO
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED	6198	35	Benefit maximum has been reached.			CO
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED	6221 6222 6311 6421 6423 6424 6425 6426 6427 6428 6429	35	Benefit maximum has been reached.			CO
2018	DIABETIC SUPPLIES LIMITS EXCEEDED	6493 6494 6495 6496 6497 6499	35	Benefit maximum has been reached.			CO
2019	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED	6176 6477	119	Benefit maximum for this time period has been reached.			CO
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED	6254	119	Benefit maximum for this time period has been reached.			CO
2021	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED	6168 6169	119	Benefit maximum for this time period has been reached.			CO
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE	6171 6196 6212 6223 6224 6225 6226 6227 6228 6229 6230 6231 6248 6286 6313 6372 6498 6502	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2023	DEALER LIMITS EXCEEDED	6506 6507	119	Benefit maximum for this time period has been reached.			CO
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE	6249 6250	23	Payment adjusted because charges have been paid by another payer.			CO
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS	6251 6252 6253 6255 6256	35	Benefit maximum has been reached.			CO
2026	EXCEEDS EPSDT CLINIC LIMITS	6178 6179 6180 6181	35	Benefit maximum has been reached.			CO
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS	6216 6312 6317 6503	119	Benefit maximum for this time period has been reached.			CO
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR	6244 6501	35	Benefit maximum has been reached.			CO
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS	6268 6269 6270 6271 6272 6273 6274 6275 6276 6277 6278 6279	35	Benefit maximum has been reached.			CO
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE	6373	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2033	HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS	6195	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS	6247	119	Benefit maximum for this time period has been reached.			CO
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED	6143 6152 6316 6492 6504	119	Benefit maximum for this time period has been reached.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2036	ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION	436 6281 6512	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.			CO
2037	MAXIMUM PAYMENT MADE	5106 5107 5108 6315	35	Benefit maximum has been reached.			CO
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH	6430 6431 6432 6433 6434 6435 6436 6437 6438 6439 6440 6441	119	Benefit maximum for this time period has been reached.			CO
2039	TARGETED ULTRASOUND/AMNIOCENTESIS REVIEW	6422	133	The disposition of this claim/service is pending further review.			OA
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED	6450 6451 6510 6511	35	Benefit maximum has been reached.			CO
2042	EXCEEDS ONCE PER MONTH LIMIT	6452 6453 6454 6455 6456 6457 6505	119	Benefit maximum for this time period has been reached.			CO
2043	ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD	6147	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2044	PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV.	6458	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2048	CONFLICTING DENTAL SERVICE SAME DAY	6446 6447 6448 6449	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2055	2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED	6322	119	Benefit maximum for this time period has been reached.			CO
2056	TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED	6375 6376	35	Benefit maximum has been reached.			CO
2057	OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED	6461 6462 6463 6464 6465 6466 6467 6468 6483 6484 6485 6486	35	Benefit maximum has been reached.			CO
2058	YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED	6479 6480 6481	35	Benefit maximum has been reached.			CO
2074	PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS	6314	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2078	MEMBER HAS MULTIPLE BENEFIT PLANS FOR THE DATE OF SERVICE RANGE.	2078 6142 6188 6233	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO
2090	PCS - 1500	1044	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT	1045	133	The disposition of this claim/service is pending further review.			OA
2099	MANUALLY SUSPEND FOR HCA	595	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE	1012	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	Missing/incomplete/invalid procedure code(s) and/or rates.	CO
2105	INVALID DIAGNOSIS FOR PROCEDURE	4037	11	The diagnosis is inconsistent with the procedure.			CO
2110	PCS CLAIM - MEMBER NOT PCS ELIGIBLE	2008	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	N30	Recipient ineligible for this service.	OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE	568	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD	6657	B15	Payment adjusted because this procedure/service is not paid separately.			OA
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	526	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid "from" date(s) of service.	CO
2127	DATE RECEIVED FOR PROCESSING- PRIOR TO DATE OF SERV	536 4806	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid "from" date(s) of service.	CO
2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV	569	110	BILLING DATE PREDATES SERVICE DATE.			CO
2132	MISSING TOTAL CLAIM CHARGE	270	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.	CO
2133	INVALID TOTAL CLAIM CHARGE	271	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.	CO
2138	MISSING/INVALID TYPE OF BILL	273 274	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO
2140	HCPC CODE IS INVALID FOR REVENUE CODE	520	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2141	TOTAL DAYS LESS THAN COVERED DAYS	570	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2143	REFILLS EXHAUSTED	4024	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			CO
2144	INVALID REFILL INDICATOR VALUE	211	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2151	MISSING PRESCRIBING PROVIDER NUMBER	205 225	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	CO
2153	INVALID DRUG CODE	218	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N60	A valid NDC is required for payment of drug claims effective October 02.	CO
2154	MISSING PRESCRIPTION NUMBER	212	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO
2160	MISSING DIAGNOSIS INDICATOR	223	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO
2163	MISSING DIAGNOSIS CODE	258	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.	CO
2166	MEMBER ELIGIBILITY PENDING DHS APPROVAL	2013 2072 2074	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2168	INVALID SOURCE OF ADMISSION	229	129	Payment denied - Prior processing information appears incorrect.	MA42	Missing/incomplete/invalid admission source.	OA
2175	SURGICAL PROCEDURE MISSING	571	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	Missing/incomplete/invalid procedure code(s) and/or rates.	CO
2179	MISSING TOOTH SURFACE	266	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.	CO
2183	MISSING UNITS OF SERVICE	260 400	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.	CO
2185	LTC MISSING ADMISSION DATE	4197	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA40	Missing/incomplete/invalid admission date.	CO
2191	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM	518	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES	4085	96	Non-covered charge(s).			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER	230	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	CO
2199	DATE OF SURGERY IS MISSING	370 371 373 374 376 377 379 380 474 475	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2200	INVALID TYPE OF ADMISSION	279	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA41	Missing/incomplete/invalid admission type.	CO
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE	4226	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2203	CLAIMANT SIGNATURE MISSING	228 7262 7264 7265 7272 7273 7278 7279	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO
2207	INVALID LEVEL OF CARE	1023	129	Payment denied - Prior processing information appears incorrect.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	OA
2208	INVALID PICKUP LOCATION	531	129	Payment denied - Prior processing information appears incorrect.	N53	Missing/incomplete/invalid point of pick-up address.	OA
2210	FACILITY PROVIDER SERVICE LOCATION IS MISSING	209	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
2214	DATE PRESCRIBED IS INVALID	213 214	B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.			CO
2215	DATE DISPENSED IS MISSING	215	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2216	DATE DISPENSED IS INVALID	216	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2222	MISSING OCCURRENCE DATE	295 297 299 301 411 413 415 417 465	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	Missing/incomplete/invalid occurrence codes or dates.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2224	INVALID OCCURRENCE DATE	296 298 302 412 414 416 418 466	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	Missing/incomplete/invalid occurrence codes or dates.	CO
2226	INVALID CONDITION CODE	284 285 286 287 288 289 290 471	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.	CO
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE	393 394 433 434	2	Coinsurance Amount			PR
2231	ESTIMATED DAYS SUPPLY INVALID	222	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2233	INSURANCE DENIAL REQUIRED	2506 2508	129	Payment denied - Prior processing information appears incorrect.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	OA
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE	530 575	129	Payment denied - Prior processing information appears incorrect.			OA
2237	FACILITY PROVIDER NOT IN VALID FORMAT	236	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
2239	INVALID OCCURRENCE CODE	291 292 293 294 405 406 407 408 409 410 464 467	129	Payment denied - Prior processing information appears incorrect.	M45	Missing/incomplete/invalid occurrence codes or dates.	OA
2242	MISSING OCCURRENCE CODE	245	129	Payment denied - Prior processing information appears incorrect.	M45	Missing/incomplete/invalid occurrence codes or dates.	OA
2244	INVALID PAY-TO PROVIDER NUMBER	255	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			OA
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	247	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2249	CLAIM HAS NO DETAILS	250	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	CO
2252	MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES	2077	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.			CO
2265	CLAIM HAS THIRD-PARTY PAYMENT	576	100	Payment made to patient/insured/responsible party.	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full	OA
2274	CLAIM INDICATES MEMBER EXPIRED	2044	100	Payment made to patient/insured/responsible party.			OA
2277	LTC ELIGIBILITY ERROR	1024	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2282	PHYSICIAN AUDITOR REVIEW-MODIFIER 24	4010	133	The disposition of this claim/service is pending further review.			OA
2296	PROVIDER INELIGIBLE FOR PROCEDURES	254	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2300	NO PROVIDER MASTER RECORD	1051	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA
2302	PRESCRIBING PROVIDER NOT ON FILE	1020 1021 1022 1026	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	OA
2310	ANESTHESIA MODIFIER IS INVALID OR MISSING	4228	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M78	Missing/incomplete/invalid HCPCS modifier.	CO
2313	DIAGNOSIS CODE MISSING/NOT ON FILE	244 246 355 356 357 358 359 360 361 362 4047 4048 4049 4050	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
2314	SURGICAL PROCEDURE CODE NOT FOUND	363 366 369 372 375 378 473 4056 4057 4058 4128	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO
2315	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	457	96	Non-covered charge(s).			CO
2316	ATTACHMENT CONTROL NUMBER MISSING	599	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2317	INVALID/MISSING MODIFIER FOR THIS PROCEDURE	251 252 253 4097 4245	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.	CO
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	455	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2322	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	4046	96	Non-covered charge(s).			CO
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION	534	B12	Services not documented in patients' medical records.	N66	Missing/incomplete/invalid documentation.	CO
2335	LTC MEMBER - NONCOMP DRUG	7024	100	Payment made to patient/insured/responsible party.			OA
2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS	351 7025	96	Non-covered charge(s).			CO
2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION	3002	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.			CO
2338	LTC DRUG ONLY	7026	100	Payment made to patient/insured/responsible party.			OA
2345	ATTENDING PROVIDER NOT FOUND	381 382 1054	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M68	Missing/incomplete/invalid attending or referring physician identification.	CO
2346	REFERRING PROVIDER NOT FOUND	1027	100	Payment made to patient/insured/responsible party.	M68	Missing/incomplete/invalid attending or referring physician identification.	OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.	350	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2351	SUBMITTED TO ALLOWED EXCEEDS PERCENT	4084	100	Payment made to patient/insured/responsible party.			OA
2352	ALLOWED TO SUBMITTED EXCEEDS PERCENT	4006 4009	100	Payment made to patient/insured/responsible party.			OA
2356	NDC IS DEACTIVATED AND NOT PAYABLE ON DATE FILLED	4007	96	Non-covered charge(s).			CO
2362	MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM	436 4230	1	Deductible Amount			PR
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID	559	23	Payment adjusted because charges have been paid by another payer.			CO
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION	4233	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	2045	100	Payment made to patient/insured/responsible party.			OA
2388	IMPROPER MODIFIER FOR CRNA	4235	96	Non-covered charge(s).	M78	Missing/incomplete/invalid HCPCS modifier.	CO
2391	INVALID USE OF E DIAGNOSIS CODE	4236	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2402	INVALID TYPE OF LEAVE	4237	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2406	LTC LEAVE DATES CONFLICT	526	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2416	AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE	4238	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
2417	REVIEW AMBULANCE NON ROUTINE DESTINATION	4239	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
2425	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE	4240	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2450	INVALID QUADRANT	450	11	The diagnosis is inconsistent with the procedure.			CO
2452	RENDERING PROVIDER SERVICE LOCATION IS MISSING	452 453	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.			OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2453	INVALID DIAGNOSIS TREATMENT INDICATOR	459	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
2454	INVALID ASSIGNMENT CODE	454	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2456	INVALID PROCEDURE TYPE	456	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2460	CANNOT DETERMINE THE INPATIENT LEVEL OF CARE	4241	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2462	INVALID/MISSING SPAN DATE	419 420 421 422 423 424 425 426 468 469 470 472	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M46	Missing/incomplete/invalid occurrence span code or dates.	CO
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE	510 511 581 605	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M46	Missing/incomplete/invalid occurrence span code or dates.	CO
2474	DATE DISPENSED AFTER BILLING DATE	503	110	BILLING DATE PREDATES SERVICE DATE.			CO
2476	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID	597	35	Benefit maximum has been reached.			CO
2477	THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT	458	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	502	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE	585	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2491	DRUG NOT APPROVED	7035	96	Non-covered charge(s).			CO
2505	CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT.	2505	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
2510	THIS PATIENT HAS TWO COVERAGE TYPES	2507	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE	586	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	Missing/incomplete/invalid occurrence codes or dates.	CO
2530	TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE	7030	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2532	DISEASE STATE MANAGEMENT	7071	100	Payment made to patient/insured/responsible party.			OA
2535	PDUR INGREDIENT DUPLICATION	7062	100	Payment made to patient/insured/responsible party.			OA
2538	HMO CO-PAY/MEMBER HAS TPL	2510	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
2546	DRUG DISEASE MARKER	7070	100	Payment made to patient/insured/responsible party.			OA
2547	HMO CO-PAY/MEMBER HAS MEDICARE	2511	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
2564	SUPPLEMENTAL DELIVERY PYMT DENIAL CODE	587	29	The time limit for filing has expired.			CO
2567	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE	2512	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			CO
2588	STOP LOSS NOT APPROVED	2059	25	Payment denied. Your Stop loss deductible has not been met.			CO
2599	STOP LOSS THRESHOLD REACHED	3018	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2600	UNITS NOT EQUAL TO TEETH BILLED	4200	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2601	PART A CROSSOVER SPANS 20020501	609	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2605	PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH	3020	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			CO
2623	ADJUSTMENT HAS AUTO DENIAL	589	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2625	FUND CODE UNDETERMINED	2054	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			CO
2627	COVERED FOR ORAL PATH ONLY	4243	96	Non-covered charge(s).			CO
2634	DETAIL ATTENDING PHYSICIAN ID INVALID	476	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2635	DETAIL FIRST OTHER PHYSICIAN ID INVALID	477	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2636	DETAIL SECOND OTHER PHYS ID INVALID	478	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
2638	DRUG REQUIRES MEDICAL REVIEW/CN	7061	133	The disposition of this claim/service is pending further review.			OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
2649	FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS	590	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	CO
2660	ZERO AMOUNT TO PAY	4200	92	Claim Paid in full.			CO
2673	SUBMIT PAPER CLAIM	7036	45	Charges exceed your contracted/ legislated fee arrangement.			CO
2697	QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY	2007	31	Claim denied as patient cannot be identified as our insured.			CO
2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN	4066	11	The diagnosis is inconsistent with the procedure.			CO
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM	5012	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
2849	INVALID MODIFIER COMBINATION	4011	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
2850	LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM	5501	133	The disposition of this claim/service is pending further review.			OA
2851	LTC-HOME HEALTH CLAIM CONFLICT	5502	133	The disposition of this claim/service is pending further review.			OA
2852	LTC-PCS POSSIBLE CONFLICT	5503	133	The disposition of this claim/service is pending further review.			OA
2854	INPATIENT-PCS POSSIBLE CONFLICT	5504	133	The disposition of this claim/service is pending further review.			OA
2856	HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM	5505	133	The disposition of this claim/service is pending further review.			OA
2857	INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT	5506	133	The disposition of this claim/service is pending further review.			OA
2858	INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM	5507	133	The disposition of this claim/service is pending further review.			OA
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK	3019	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N45	Payment based on authorized amount.	CO
2880	PRODEDURE CODE NOT VALID FOR FORM	534	96	Non-covered charge(s).			CO
2882	LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM	5508	133	The disposition of this claim/service is pending further review.			OA
2883	CROSSOVER-PCS POSSIBLE CONFLICT	5509	133	The disposition of this claim/service is pending further review.			OA
2895	RURAL HEALTH CLINIC REQUIRES REVENUE OP521	4247	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).	CO
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	596	129	Payment denied - Prior processing information appears incorrect.	N61	Rebill services on separate claims.	OA
3001	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL.	3001 3301	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.	CO
3037	MEMBER NUMBER HAS BEEN DEACTIVATED	2037	45	Charges exceed your contracted/ legislated fee arrangement.			CO
3360	TAXONOMY CODE INVALID	1009 1928 1929 1930 1931 1932 1933 1934 1935 6514	45	Charges exceed your contracted/ legislated fee arrangement.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
3362	PA NUMBER OR PA PAYMENT METHOD IS NOT VALID	3362	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			CO
3999	CLAIM BILLED WITH INACTIVE MID	2999	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM	4000	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4014	NO PRICING SEGMENT IS ON FILE.	4105	133	The disposition of this claim/service is pending further review.			OA
4039	DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS	4039	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
4089	MISSING OR INVALID SURGERY CODE- PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT	4089	96	Non-covered charge(s).			CO
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL	4095	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4098	PRICING BEING REVIEWED	565 4098	133	The disposition of this claim/service is pending further review.			OA
4107	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PROVIDED	4107	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4108	NO ASC ON FILE	4108	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4114	PRICING BEING REVIEWED	4114	133	The disposition of this claim/service is pending further review.			OA
4115	PRICING BEING REVIEWED	4115 4123 4124	133	The disposition of this claim/service is pending further review.			OA
4122	VALUE CODE IS INVALID	461	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4123	VALUE CODE AMOUNT IS MISSING	462	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4124	VALUE CODE AMOUNT IS INVALID	463	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4127	CANNOT PRIORITIZE MEMBER'S PROGRAMS	4127	133	The disposition of this claim/service is pending further review.			OA
4203	THIS SERVICE IS A NON-COVERED OKLAHOMA HEALTH COVERAGE PROGRAM SERVICE AS THE RENDERING PROVIDER IS NOT RECOGNIZED BY THE OKLAHOMA HEALTH COVERAGE PROGRAM.	4203	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			CO
4218	INVALID PROCEDURE FOR CLAIM FORM	4218	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N34	Incorrect claim form for this service.	OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
4220	EPOGEN REQUIRES VALUE CODE 68	4220	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M49	Missing/incomplete/invalid value code(s) or amount(s).	OA
4227	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.	4227	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	4246	45	Charges exceed your contracted/ legislated fee arrangement.			CO
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	4251	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	4252	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4257	THIS PROCEDURE CODE/MODIFIER COMBINATION IS NOT COVERED FOR THIS PROVIDER CONTR ACT.	4257	96	Non-covered charge(s).	M51	Missing/incomplete/invalid procedure code(s) and/or rates.	CO
4381	NO REIMBURSEMENT RULE ON FILE.	4381 4831	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4385	MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE CODE	4385	177	Payment denied because the patient has not met the required eligibility requirements			CO
4386	PROVIDER CONTRACT - PROCEDURE NOT BILLABLE WITH REVENUE CODE	4386	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4387	REIMBURSEMENT - PROCEDURE NOT PAYABLE WITH REVENUE CODE	4387	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4391	THE LENGTH OF STAY ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT.	4391	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
4393	CONTRACT INVALID REVENUE/PROCEDURE COMBO	4393	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.	5000 5007 5008 5009 5011	18	Duplicate claim/service.			CO
5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.	5001	18	Duplicate claim/service.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT.	5002	18	Duplicate claim/service.			CO
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL.	5003	18	Duplicate claim/service.			CO
5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL.	5004	45	Charges exceed your contracted/ legislated fee arrangement.			CO
5006	REVERSAL NOT PROCESSED, CLAIM OVER 60 DAYS - SUBMIT MANUAL ADJUSTMENT.	5006	29	The time limit for filing has expired.			CO
5010	EXACT DUPLICATE - TOOTH SURFACE	5010	18	Duplicate claim/service.			CO
5102	PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99348)	5102	45	Charges exceed your contracted/ legislated fee arrangement.			CO
5110	CLAIM DETAIL DENIED. MUST BILL INTRAORAL COMPLETE SERIES	5110	18	Duplicate claim/service.			CO
7200	MISCELLANEOUS CLAIMCHECK ERROR	7200	6	The procedure code is inconsistent with the patient's age.			CO
7240	SMARTSUSPENSE SUSPEND	7240	45	Charges exceed your contracted/ legislated fee arrangement.			CO
7241	SMARTSUSPENSE DENIAL	7241	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
7242	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED	7242	11	The diagnosis is inconsistent with the procedure.			CO
7243	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED	7243	11	The diagnosis is inconsistent with the procedure.			CO
7244	MEDICAL VISIT DENIED	7244	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT	7245	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT	7246	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT	7247	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS	7248	11	The diagnosis is inconsistent with the procedure.			CO
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT	7249	18	Duplicate claim/service.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT	7250	18	Duplicate claim/service.			CO
7251	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	7251	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	7252	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	7253	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	7254	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC	7255	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE	7256	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE	7257	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
7258	REVIEW MODIFIER 51	7258	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS	7259	35	Benefit maximum has been reached.			CO
7260	MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING	7260	35	Benefit maximum has been reached.			CO
7261	INVALID PROCEDURE CODE	7261	96	Non-covered charge(s).	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE	7262	14	The date of birth follows the date of service.			CO
7263	DOS REQUIRED FOR PROCEDURE	7263	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA06	Missing/incomplete/invalid beginning and/or ending date(s).	CO
7264	DOS CANNOT BE A FUTURE DATE	7264	110	BILLING DATE PREDATES SERVICE DATE.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).	CO
7265	BIRTHDATE CANNOT BE A FUTURE DATE	7265	14	The date of birth follows the date of service.	MA38	Missing/incomplete/invalid birth date.	CO
7266	AGE CANNOT BE GREATER THAN 124 YEARS	7266	6	The procedure code is inconsistent with the patient's age.	MA38	Missing/incomplete/invalid birth date.	CO
7267	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES	7267	18	Duplicate claim/service.			CO
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES	7268	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M57	Missing/incomplete/invalid provider identifier.	OA

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7269	MODIFIER NOT VALID FOR THIS PROCEDURE	7269	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.	CO
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION	7270	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.	CO
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID	7271	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M57	Missing/incomplete/invalid provider identifier.	OA
7272	DIAGNOSIS 1 MUST BE A VALID CODE	7272	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
7273	DIAGNOSIS 2 MUST BE A VALID CODE	7273	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
7274	DIAGNOSIS 3 MUST BE A VALID CODE	7274	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
7275	DIAGNOSIS 4 MUST BE A VALID CODE	7275	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
7276	DIAGNOSIS MUST BE A VALID CODE	7276	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			CO
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE	7277	11	The diagnosis is inconsistent with the procedure.			CO
7278	INVALID DATE (DATE OF BIRTH)	7278	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO
7279	INVALID AMOUNT CHARGED	7279	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA54	Physician certification or election consent for hospice care not received timely.	OA
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED	7280	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			OA
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE	7281	11	The diagnosis is inconsistent with the procedure.			CO
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS	7282	11	The diagnosis is inconsistent with the procedure.			CO
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT	7283	45	Charges exceed your contracted/ legislated fee arrangement.			CO
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT	7284	133	The disposition of this claim/service is pending further review.			OA
7285	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	7285	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7286	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR	7286	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.			CO
7288	SMARTSUSPENSE FLAG	7288	133	The disposition of this claim/service is pending further review.			OA

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
7289	SMARTSUSPENSE MONITOR	7289	133	The disposition of this claim/service is pending further review.			OA
7290	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE	7290	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE	7291	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			CO
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER.	4130 4131	63	Correction to a prior claim.			CO
8039	YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM. PLEASE RESUBMIT YOUR ORIGINAL CLAIM, WITH CORRECTIONS, FOR PROCESSING.	550	63	Correction to a prior claim.			CO
8600	ZERO CREDIT BALANCE	3007 4224 6019 6141	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT.	505	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	N219	Payment based on previous payer's allowed amount.	OA
9025	837 ADJUSTMENT ERROR -- ORIGINAL CLAIM NOT FOUND	9025	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9111	INTERNAL PROCESSING ERROR - CONTACT SE MANAGER	911	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.	603	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.	607	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9664	THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED.	600	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
9665	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS.	601	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
9666	THE ATTACHMENT TYPE IS NOT VALID.	460 480	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	5401	45	Charges exceed your contracted/ legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	CO
9954	KY DEFAULT PERCENTAGE PRICING APPLIED	3313	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			CO
9991	REFUND AMOUNT LESS THAN ADJUSTED AMOUNT	9991	88	Adjustment amount represents collection against receivable created in prior overpayment.			CO
9992	REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT	9992	123	Payer refund due to overpayment.			CO
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	273 505 1049 1902 1903 1904 1905 1906 1907 1908 1912 1913 1914 1915 1916 1917 1918 1919	45	Charges exceed your contracted/ legislated fee arrangement.			
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	1956 1957 1958 1959 1961 1962 1963 1967 1968 1969 1970 1971 1972 2601 2608 3315 3325 3369 3385 3997 3998 3999 4001 4016	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4044 4045 4061 4062 4068 4069 4071 4072 4073 4074 4075 4076 4078 4079 4080 4083 4086 4087	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4110 4112 4117 4118 4119 4121 4122 4125 4126 4129 4132 4136 4137 4138 4139 4143 4144 4146 4147 4148 4153 4154 4155 4158	45	Charges exceed your contracted/ legislated fee arrangement.			
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4171 4172 4173 4174 4175 4176 4177 4178 4179 4180 4190 4191 4192 4193 4194 4195 4196 4204 4205 4206 4210 4219 4221 4222	45	Charges exceed your contracted/ legislated fee arrangement.			
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4253 4254 4255 4256 4258 4310 4312 4313 4317 4319 4320 4321 4322 4361 4362 4363 4364 4372 4373 4375 4712 4713 4716 4723	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4741 4742 4743 4744 4762 4763 4766 4767 4768 4775 4806 4814 4822 4845 4861 4862 4863 4864 4865 4872 4875 4876 48814883	45	Charges exceed your contracted/ legislated fee arrangement.			
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4904 4905 4906 4907 4910 4911 4912 4913 4917 4920 4921 4922 4923 4930 4931 4933 4935 4936	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES.	4953 4960 4961 4965 4966 4967 4971 4972 4973 4976 4977 4980 4981 4982 4983 4991 4992 4993	45	Charges exceed your contracted/ legislated fee arrangement.			CO
9999	PROCESSED PER MEDICAID POLICY	214 218 222 227 241 255 295 296 297 298 299 301 032 355 362 366 369 370 371 372 373 374 375 376 377 378 379 380 383 384 402 408 427 435 436 437 456 460 466 480	92	Claim Paid in full.			CO
9999	PROCESSED PER MEDICAID POLICY	554 595 603 607 1005 1016 1019 1020 1021 1022 1023 1041 1072 1562 2000 2011 2015 2016 2031	92	Claim Paid in full.			CO
9999	PROCESSED PER MEDICAID POLICY	3336 3373 3374 3375 3376 3377 3378 4007 4015 4027 4033 4050 4051 4066 4081 4082 4089 4096	92	Claim Paid in full.			CO

EOB	Medicaid Description	ESC	HIPAA ADJ RSN	HIPAA ADJ RSN Description	HIPAA Remark	HIPAA Remark Description	GROUP
9999	PROCESSED PER MEDICAID POLICY	4115 4116 4132 4133 4135 4145 4163 4202 4213 4217 4242 4380 4834 4835 4885 5924 5925 5926	92	Claim Paid in full.			CO
9999	PROCESSED PER MEDICAID POLICY	8505 8506 8507 8508 8509 8510 8511 8512 8513 8514 8515 8516	92	Claim Paid in full.			CO