



EOB Codes *Kentucky MMIS Project*

*Cabinet for Health and Family Services
Kentucky Medicaid Office*

June 4, 2008

Cabinet for Health and Family Services Kentucky Medicaid Office	
Role:	Name:
Author	EDS
Reviewer	EDS Implementation Leads, PMO
EDS Management	EDS Management Team
Client	Commissioner Elizabeth Johnson Deputy Commissioner Carrie Banahan Claims Division Director Rhonda Poston Executive Director/CIO Lorna S. Jones Chief Technical Officer Sandeep Kapoor
DELIVERABLE TITLE: EOB Codes	DATE SUBMITTED: June 4, 2008
LOCATION and FILE NAME: EOB Codes.doc	AUTHORING TOOL: MSWord2003

Document Change Log

Version	Changed Date	Changed By	Reason
1.0	04/01/2008	Ann Murray	Document Creation
1.1	06/04/2008	Ann Murray	Added new codes and updated existing codes

Table of Contents

1	EOB Codes.....	1
---	----------------	---

1 EOB Codes

CODE	DESCRIPTION
0001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR I
0002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF
0003	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING,
0004	MEDICARE PAID DATE IS MISSING OR INVALID.
0005	EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM
0006	THE DISCHARGE DATE IS MISSING OR INVALID.
0007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.
0008	CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MU
0009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIM
0010	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT.
0011	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN
0012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVIC
0013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.
0014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID.
0015	CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS
0016	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.

CODE	DESCRIPTION
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.
0018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.
0020	MEDICARE DOCUMENTATION NOT ATTACHED.
0021	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.
0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
0023	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.
0024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.
0025	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.
0026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUS
0027	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.
0028	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.
0029	CLAIM REQUIRES DOCUMENTATIION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC
0030	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.
0031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.
0032	CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE.
0033	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES
0034	DENIED BY MEDICARE.
0035	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE

CODE	DESCRIPTION
0036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.
0037	MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVI
0038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.
0039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.
0040	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.
0041	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE,
0042	CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB.
0043	CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID.
0044	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID.
0045	TYPE OF BILL INVALID FOR PROVIDER TYPE.
0046	CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE.
0047	PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE
0048	CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MAN UAL AN
0049	CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL.
0052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS.
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER

CODE	DESCRIPTION
	INSURANCE.
0054	CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM
0055	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED.
0056	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIV
0057	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.
0058	CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
0059	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID.
0060	CLAIM DENIED. LOCATION CODE INVALID.
0061	PAID IN FULL BY MEDICAID.
0062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.
0063	CLAIM DENIED. AN 8-DIGIT LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FORM
0064	THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN.
0065	DESTINATION CODE IS MISSING/INVALID.
0066	PRO STICKER/INDICATOR MISSING OR INVALID
0067	FAMILY PLANNING INDICATOR INVALID.
0068	AM/PM PICK-UP INDICATOR MISSING OR INVALID.
0069	TIME OF CALL IN MISSING/INVALID.
0070	TIME OF PICK UP IS MISSING OR INVALID.
0071	DESTINATION CODE MISSING/INVALID.
0072	PICK-UP LOCATION CODE MISSING OR INVALID.

CODE	DESCRIPTION
0073	REFERRED TO 'OTHER' CODE INVALID.
0074	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PR
0075	CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAG
0076	OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID.
0077	CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING
0078	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.
0079	CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES).
0080	PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE.
0081	CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID.
0082	CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID.
0083	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID
0084	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.
0085	CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER
0086	PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLL MENT A
0087	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.
0088	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.
0089	DETAIL CHARGE MISSING OR INVALID.
0090	CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID.
0091	CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR

CODE	DESCRIPTION
0092	THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT.
0093	THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES.
0094	PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVIC
0095	CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM
0096	MEMBER'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE.
0097	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.
0098	MEMBER MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.
0099	PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF MEMBER SIGNATURE BUT PRI
0100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID.
0101	DETAIL TO DATE OF SERVICE MISSING OR INVALID.
0102	CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT.
0103	MISSING OR ALTERED MEMBER SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE.
0105	CLAIM DENIED. CLAIM SUBMITTED FOR HEARING AID AND HEARING AID PARTS SHALL REFL
0106	INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES.
0107	INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT
0108	CONSENT FORM IS INCOMPLETE
0109	INCORRECT STERLIZATION CONSENT FORM USED.
0110	CLAIM SUSPENDED FOR REVIEW.

CODE	DESCRIPTION
0111	ADJUSTMENT REQUEST IN PROCESS
0112	CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILING
0113	CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE.
0114	REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PR
0115	PAYMENT APPLIED TO RECEIVABLE.
0116	DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL.
0117	CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM.
0118	OUR RECORDS INDICATE PAID IN FULL BY MEDICARE.
0119	NOT COVERED UNDER THE PROGRAM EXCEPT UNDER EPSDT.
0120	LAB PROCESSING CHARGE INCLUDED IN FLAT FEE.
0121	THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY MEMBER
0122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDI
0123	CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY. PLEASE REFER T
0124	CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR MEMBERS AGE 22 THROU
0125	THE TOOTH NUMBER IS MISSING OR INVALID.
0126	PROCEDURE CODE(S) IS INVALID FOR OTHER THAN ANTERIOR TOOTH NUMBERS.
0127	CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID.
0128	THE TOOTH NUMBER IS MISSING OR INVALID.
0129	KYCONV-DESCRIPTION NOT FOUND

CODE	DESCRIPTION
0130	CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXC
0131	CLAIM/DETAIL DENIED. CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED
0132	SERVICE NOT AUTHORIZED.
0133	THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION (PA). CURRENTLY, EDITING
0134	MAP-34 FORM INCOMPLETE.
0135	CLAIM/DETAIL DENIED. FULL MOUTH DEBRIDEMENT IS ONLY PAYABLE FOR
0136	PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE.
0137	CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHA
0138	CLAIM DENIED. LOCK-IN MEMBER.
0139	CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PE
0140	CLAIM PENDING REVIEW. MEMBER IS A POTENTIAL LOCK-IN MEMBER.
0141	PROCEDURE CODE MODIFIER MISSING/INVALID.
0142	CLAIM DENIED. PREGNACY INDICATOR INVALID FOR MEMBERENT AGE OR SEX.
0143	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE.
0144	SHOULD BE BILLED BY PROVIDER OF SERVICE.
0145	THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY.
0146	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE.
0147	PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER.
0148	THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE.

CODE	DESCRIPTION
0149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBER'S AGE.
0150	THIS PROCEDURE IS INVALID FOR THE MEMBER'S SEX.
0151	CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE
0152	PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY KENTUCKY MEDICAID.
0153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
0154	PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER.
0155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR I
0156	THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER.
0157	PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY.
0158	CLAIM DENIED DUE TO INJURY DIAGNOSIS.
0159	MORE THAN ONE VISIT PER DETAIL DATE OF SERVICE NOT ALLOWED. EACH VISIT MUST BE
0160	PROCEDURE INVALID FOR TOOTH NUMBER INDICATED.
0161	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE.
0162	CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF
0163	CLAIM DETAIL DENIED. EMPLOYEE ID/PERSONAL IDENTIFIER MISSING OR INVALID.
0164	PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.
0165	SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.
0166	CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBER'S AGE.
0167	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS AGE.

CODE	DESCRIPTION
0168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX.
0169	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX
0170	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.
0171	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.
0172	SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
0173	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
0174	PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE
0175	PROVIDER ON REVIEW FOR SECONDARY SURGICAL PROCEDURE
0176	SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
0177	SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
0178	EXPECTED DATE OF DELIVERY MUST BE AT LEAST 30 DAYS FROM DATE OF CONSENT.
0179	CLAIM DENIED-PLEASE RESUBMIT CLAIM WITH REPORT OF PROCEDURE PERFORMED.
0180	DETAIL PROCEDURE INDICATE AS ON REVIEW.
0181	RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED.
0182	RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE.
0183	RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED.
0184	RESUBMIT WITH MAP-235 OR MAP-236 ATTACHED IF APPROPRIATE.
0185	CONSENT FORM MUST BE SIGNED BY MEMBER 30 DAYS PRIOR TO STERILIZATION
0186	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY MEMBER.
0187	STAMPED SIGNATURES ARE UNACCEPTABLE.

CODE	DESCRIPTION
0188	CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RE
0189	CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATION
0190	THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOS
0191	THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE
0192	THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE.
0193	THE SECONDARY DIAGNOSIS IS INVALID FOR THE MEMBER'S AGE.
0194	DIAGNOSIS IS INVALID FOR MEMBER'S SEX.
0195	THE SECONDARY DIAGONISIS IS INVALID FOR MEMBER SEX.
0196	THE BILLED DIAGNOSIS IS ON REVIEW.
0197	CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH,
0198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH.
0199	CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE
0200	CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS.
0201	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
0202	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
0203	CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT A
0204	INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.

CODE	DESCRIPTION
0205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE
0206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
0207	DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE.
0208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS
0209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDUR
0210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.
0211	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE.
0212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.
0213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGN
0214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.
0215	CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS
0216	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX.
0217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE.
0218	FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX.
0219	FOURTH HEADER DIAGNOSIS ON REVIEW.
0220	SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE
0221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE.
0222	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
0223	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
0224	CLAIM DENIED. MISSING OR INVALID DIAGNOSIS CODE.

CODE	DESCRIPTION
0225	NO HISTORY MATCH FOUND, PLEASE RESUBMIT.
0226	CANNOT BE PROCESSED ON THIS CLAIM FORM.
0227	CLAIM OVERLAPS YOUR FISCAL YEAR END.
0228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE.
0229	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE.
0230	THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE.
0231	CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER
0232	CLAIM/DETAIL DENIED. ACTION REASON CODE INDICATES PROVIDER IS ON REVIEW.
0233	UPIN MISSING OR INVALID.
0234	CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW.
0235	SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM.
0236	PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER.
0237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE.
0238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.
0239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE.
0240	MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE.
0241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY.
0242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26.
0243	PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS P

CODE	DESCRIPTION
0244	PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SE
0245	THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER.
0246	80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAM
0247	PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIGIBLE FOR THE DATE OF SERVIC
0248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM.
0249	PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT IN FACILITY FOR ALL OF
0250	THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER.
0251	INCORRECT MEMBER IDENTIFICATION NUMBER.
0252	MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DAT
0253	OUR RECORDS INDICATE THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVIC
0254	THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES.
0255	MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES.
0256	OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL
0257	OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERV
0258	MEDICARE SUSPECT/DENTAL.
0259	THE MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE.
0260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY

CODE	DESCRIPTION
	RESPONSIBLE FOR
0261	OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR T O THE ENDING DATE OF
0262	MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE.
0263	CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE.
0264	MEMBER NAME IS MISSING.
0265	INCORRECT MEMBER IDENTIFICATION NUMBER.
0266	MEMBER NOT ELIGIBLE FOR WAIVER SERVICES.
0267	WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME
0268	MEMBER ON REVIEW
0269	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENRO
0270	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER.
0271	CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF
0272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN
0273	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO CERTAIN TOOTH NUMBERS.
0274	MEMBER TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE
0275	INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID.
0276	DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATI
0277	THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT. CONTACT UNISYS PROVID

CODE	DESCRIPTION
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY
0279	CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTER
0280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCID
0281	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENT
0282	THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE.
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE.
0284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDIC
0285	REGIONAL ANESTHESIA PROCEDURE CODES MAY NOT BE BILLED USING TYPE OF SERVICE 07,
0286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE.
0287	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHN
0288	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL
0289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.
0290	PENDING CONFIRMATION OF MEMBER ELIGIBILITY.
0291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT.
0292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW.
0293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW.
0294	KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMAR

CODE	DESCRIPTION
0295	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHY
0296	CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER.
0297	MEMBER IS NOT ELIGIBLE FOR HOSPICE.
0298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE.
0299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FO
0300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
0301	CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP.
0303	THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE.
0304	OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVEL.
0305	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIO
0306	A HOSPICE MEMBER - RECYCLE FOR EDIT 298.
0307	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJU
0308	DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDIC
0310	CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE.
0311	CORRECTED PAYMENT PER ADJUSTMENT REQUEST.
0316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTE
0319	INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED.

CODE	DESCRIPTION
0320	CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS.
0321	EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED P
0322	EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING P
0325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
0326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.
0327	PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION.
0328	PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION.
0329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION
0330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED.
0331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE.
0333	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION.
0334	SUPPLY NOT COVERED ON RENTAL ITEM.
0335	LACKS REPORT TO JUSTIFY HIGHER FEE.
0337	CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PR
0340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FI
0341	AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF S
0342	AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS
0343	CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE

CODE	DESCRIPTION
0344	AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM
0345	80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS 80
0347	DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABL
0348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE.
0349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS.
0350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE O
0351	INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED.
0352	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED.
0353	INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWA
0354	MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB
0355	FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT
0356	CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS.
0357	CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED.
0359	REFER TO THE ADJUSTMENT REASON CODE.
0360	FEE ADJUSTED PER CLAIM CREDIT.
0361	GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SP
0362	PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM.
0363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION

CODE	DESCRIPTION
0364	PAYMENT REDUCED BY OTHER INSURANCE
0365	FEE ADJUSTED TO MAXIMUM ALLOWABLE.
0366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED \$50.00 PER UNIT OF SERVICE.
0367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE.
0368	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE.
0369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON S
0370	PAYMENT MODE NOT FOUND FOR BILLING PROVIDER
0371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE
0372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR
0373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY.
0374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINAN
0375	KYCONV-DESCRIPTION NOT FOUND
0376	CLAIM DENIED. MAC FIELD INVALID.
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.
0378	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED.
0379	PAID BY MEDICAID
0380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT.
0381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE
0382	DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER

CODE	DESCRIPTION
	THAN \$100.00.
0383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE
0384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.
0385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE
0386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.
0387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE
0388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE
0389	PAID CLAIM BASED UPON MEDICAL REVIEW.
0390	CLAIM DENIED. DUPLICATE SERVICE BILLED.
0391	DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON THE
0392	DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME
0393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE.
0394	HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE S
0395	THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REI
0396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE S
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM.
0398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR

CODE	DESCRIPTION
	INVALID.
0399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS MEMBER.
0403	PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE.
0404	NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332.
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
0410	FORMAT INVALID FOR ELECTRONIC CLAIMS. PLEASE CONTACT ECS HELP DESK AT 1-800-20
0411	DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERV
0412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
0413	MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.
0414	MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.
0415	FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE.
0416	CAPITATION RATE NOT WITHIN DATES OF SERVICE.
0417	CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR.
0418	CLAIM DENIED. INVALID ENCOUNTER TYPE.
0419	CLAIM DENIED. INVALID ENC RECEIPT DATE.
0420	CLAIM DENIED. INVALID ENC PAYMENT AMOUNT.
0421	CLAIM DENIED. INVALID ENC PAYMENT DATE.
0422	CLAIM DENIED. INVALID ENC ADJUSTMENT TCN.
0423	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL.
0424	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL.

CODE	DESCRIPTION
0425	DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE.
0426	THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE
0427	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION F
0428	FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE.
0429	CLAIM DENIED. PARTNERSHIP NUM MISMATCH
0430	CLAIM DENIED. ENCOUNTER, INV. TCN TO CREDIT
0431	RESERVED FOR MANAGED CARE.
0432	CLAIM DENIED. SEQ# MISMATCH ACROSS CLAIM.
0433	CLAIM DENIED. VOID/RESUB INVALID FOR XOVER.
0434	RESERVED FOR MANAGED CARE.
0435	CLAIM/DETAIL DENIED. SCL WAIVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL P
0436	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER
0437	CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAY
0438	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER M
0439	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER CALENDAR
0440	CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SU
0441	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY
0442	CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE

CODE	DESCRIPTION
	SAME DATE OF S
0443	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SA
0444	PLEASE CORRECT INVALID OR MISSING NDC NUMBER.
0445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PE
0446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PE
0447	CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY.
0448	MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250.
0449	THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAI
0450	CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER,
0451	CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO
0452	CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK.
0453	CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LI
0454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.
0455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.
0456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
0457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATI
0458	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY.

CODE	DESCRIPTION
0459	CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CA
0460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
0461	CLAIM/DETAIL DENIED. XL307/97535 LIMITED TO 80 UNITS PER WEEK.
0462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.
0463	PAY TPL CLAIM.
0464	PAY AND BILL TPL CLAIM.
0465	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT).
0466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURE
0467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUME
0469	CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK.
0472	MEMBERS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRSCRIPTION/REFILL PER DATE OF
0473	MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PA
0476	MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE.
0477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.
0478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION O
0479	CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPI
0481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.

CODE	DESCRIPTION
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST.
0484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER.
0486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM.
0487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS.
0489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.
0490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STA
0491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF
0492	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT
0493	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH
0494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBE
0496	ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER.
0497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON UNISYS ADJUSTMENT REQUEST FORM.
0498	CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE.
0499	CLAIM PENDING REVIEW OF HISTORY.
0500	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS

CODE	DESCRIPTION
0501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER.
0502	ONE FAMILY PLANNING SERVICE PER DOS.
0503	ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINI
0504	FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEA
0505	MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE.
0506	CBC AND COMPONENTS NOT ALLOWED SAME DOS.
0507	PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS.
0508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS.
0509	MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDE
0510	MEMBERS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVI
0511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSE
0512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.
0513	CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION
0514	CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY.
0515	CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.
0516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED.
0517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER

CODE	DESCRIPTION
0518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PR
0519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INC
0520	MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS.
0521	COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIV
0522	COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME.
0523	RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME
0524	IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAM
0525	IN-PATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMIS
0526	IN-PATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR
0527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREV
0528	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN
0529	CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE
0530	CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE.
0531	PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHEC
0532	RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATIO
0533	CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH

CODE	DESCRIPTION
	CLAIM INFORMATI
0534	CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER P
0535	PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FOR
0536	THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIG
0537	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOB
0538	CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION. NO
0539	CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVI
0540	HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AU
0541	CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMIT
0542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE,
0543	MULTIPLE SURGERIES FOR SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. YOUR
0544	CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 M
0545	MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLE
0546	CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) M
0547	CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED.
0548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION

CODE	DESCRIPTION
	WITH REVEN
0549	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOB
0550	PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE
0551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY.
0552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT
0553	CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATE
0554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT
0555	PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL.
0556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY.
0557	CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST
0558	CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY.
0559	CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC.
0560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.
0568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. .
0569	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0570	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.

CODE	DESCRIPTION
0571	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DUR
0572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PER
0573	DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MON
0574	CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0575	REVENUE CODE INVALID FOR DATES OF SERVICE.
0576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185.
0577	CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BIL
0578	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DUR
0579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALEN
0580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF \$1000.00 PER MEMBER FOR MINOR HO
0581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COM
0582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COM
0583	CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COM
0584	CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED T
0585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE C
0586	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES

CODE	DESCRIPTION
	PROCEDURE C
0587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBI
0588	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBI
0589	CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILL
0590	HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
0591	CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCED
0592	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHA
0593	CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH W
0594	CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION.
0596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURG
0597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.
0598	CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE.
0599	CLAIM PENDING REVIEW OF HISTORY.
0600	EYE EXAM LIMITED TO OPTOMETRIST.
0601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS.
0602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS
0603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY

CODE	DESCRIPTION
	EVERY 2 YEARS PER
0604	NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SA
0605	ONLY FOUR PSYCHIATRIC PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER.
0606	PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR TH
0607	EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER.
0608	CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER,PER CALEN
0609	CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONT
0610	CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONT
0611	MEMBER ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS.
0612	ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER MEMBER.
0613	RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS.
0614	MEMBER ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE.
0615	MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER
0616	MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES
0617	MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS.

CODE	DESCRIPTION
0618	ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS.
0619	MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR.
0620	CLAIM DENIED. MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED.
0621	DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVI
0622	DETAIL DENIED. ANNUAL LIMIT OF \$500.00 FOR MINOR HOME ADAPTIONS.
0623	MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVID
0624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER.
0625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 1
0626	CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER.
0627	CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS.
0629	MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS.
0631	MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS.
0632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY.
0633	CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND
0634	MAXIMUM \$300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN.
0635	AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER.
0636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGASSES ALLOW ONE / 12 MOS /

CODE	DESCRIPTION
0637	CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANC
0638	ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CL
0640	THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS.
0641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL.
0642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER.
0644	MEMBERS ARE LIMITED TO ONE (1) OPHTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 M
0645	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12
0646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER
0648	MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS
0649	MEMBER LMTD 1 INITIAL OPHTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS.
0650	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT.
0652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTH
0653	CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES.
0654	MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER.
0655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER
0656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.

CODE	DESCRIPTION
0657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR.
0658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER
0659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
0660	MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR.
0661	CLAIM DENIED. READMISSION WITHIN 30 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. P
0662	A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBE
0665	VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLO
0666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-M
0667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE.
0668	DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SE
0669	DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEM
0670	DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER
0671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE
0672	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$265.00 PER CALENDAR M
0673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.

CODE	DESCRIPTION
0674	PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS
0675	CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, P
0676	PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER
0677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS.
0678	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHAS
0679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE
0680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE.
0681	EVEN WITH DOCUMENTATION OF PATIENT'S CONDITION NECESSITATING ADMISSION TO A LES
0682	CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION.
0683	MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES P
0684	MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE O
0685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(
0686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE D
0687	UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION.
0688	MODEL WAIVER DOLLAR LIMIT HAS BEEN MET.
0689	MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH P

CODE	DESCRIPTION
0690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR M
0691	CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID.
0692	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE
0693	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS.
0694	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME.
0695	MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME.
0696	CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-150
0697	MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS.
0698	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER
0699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$260.00 IN
0700	CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE.
0701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIAT
0702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS
0703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS
0704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO
0705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER,

CODE	DESCRIPTION
0706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO
0707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER
0708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, P
0709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER,
0710	CLAIM/DETAIL DENIED. ONLY ONE (1) CHEMOTHERAPY ADMIN CODE IS PAYABLE ON THE SA
0711	PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT
0712	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$265.00 PER CALENDAR M
0713	DELIVERY, ROUTINE NEWBORN CARE,
0715	CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER,
0716	CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER,
0717	CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PE
0718	CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PRO
0719	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES
0722	CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL
0723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER

CODE	DESCRIPTION
0724	CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO \$1000.00 IN PAYMENTS PER
0725	INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY,PER MEMBER,P
0726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVID
0727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFE
0728	GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NU
0729	PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLA
0730	PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER.
0731	MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS.
0732	ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES
0733	PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EAC
0734	CLAIM/DETAIL DENIED.PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE
0735	CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER.
0736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PRO
0737	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER M
0738	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER

CODE	DESCRIPTION
0739	CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN
0740	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE
0741	CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICA
0742	DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER P
0743	GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVID
0744	CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SE
0745	CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PR
0746	REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE.
0747	CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINAT
0748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE.
0749	CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS.
0750	DRUG/DRUG INTERACTION.
0751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE.
0752	REVENUE CODE MISSING/INVALID.
0753	INVALID REVENUE CODE. CHARGES NOT ALLOWED.
0754	EARLY REFILL.
0755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AF

CODE	DESCRIPTION
0756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.
0757	CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RT
0758	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON
0759	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. C
0760	INFERRED DRUG/DISEASE PRECAUTION.
0761	DRUG/AGE PRECAUTION.
0762	MEDICAL CONDITION ALERT.
0763	SERVICES RENDERED DO NOT MEET DMS CRITERIA
0764	DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED.
0765	THERAPEUTIC DUPLICATION.
0766	REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED.
0767	INGREDIENT DUPLICATION.
0768	ALCOHOL PRECAUTION.
0769	BREAST FEEDING PRECAUTION.
0770	DRUG/FOOD INTERACTION.
0771	DRUG/LAB CONFLICT.
0772	CALL HELP DESK (1-800-807-1232).
0773	INVALID DUR CONFLICT CODE.
0774	INVALID DUR INTERVENTION CODE.

CODE	DESCRIPTION
0775	INVALID DUR OUTCOME CODE.
0777	CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS.
0778	VARIANCE LIMIT MET. CLAIM PENDING REVIEW.
0781	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT
0782	CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT
0783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR
0784	PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE
0785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER
0786	CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER
0788	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER
0789	CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8)
0790	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER
0791	CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK
0792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIO
0793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.
0794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED
0795	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITA
0796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR

CODE	DESCRIPTION
	YEAR) LIMITATI
0797	THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED
0798	PROCEDURE CODE XZ299 IS LIMITED TO \$150.00 PER CALENDAR MONTH PER MEMBER, PER P
0799	REVENUE CODE 270 CANNOT EXCEED \$2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT
0800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVI
0801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X
0802	PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE S
0803	MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271.
0808	MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPP
0810	HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING D
0812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME
0814	MEMBER ID NUMBER IS INVALID.
0815	CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVIC
0816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PRO
0818	VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS
0820	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHY

CODE	DESCRIPTION
0821	CLAIM DETAIL DENIED. LIMITATION EXCEEDED.
0822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES.
0824	DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OT
0825	DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC
0826	PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTA
0827	THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE
0828	CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIA
0829	CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PRO
0830	CLAIM DENIED. NO DRG FOUND.
0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.
0832	CLAIM DENIED. DRG CRITERIA NOT MET.
0833	CLAIM DENIED. DRG INVALID AGE.
0834	CLAIM DENIED. DRG INVALID SEX.
0835	CLAIM DENIED. DRG INVALID DISCHARGE STATUS.
0836	CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS.
0837	CLAIM DENIED. DRG DENY 469 THROUGH 470.
0838	PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER
0839	RESERVED FOR DRG
0840	PROCEDURE CODE HAS BEEN REBUNDLED.

CODE	DESCRIPTION
0841	BYPASS INDICATOR, GMIS INFORMATIONAL ONLY.
0842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE.
0843	PROCEDURE CODE IS INCIDENTAL.
0844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT.
0845	VISIT IS WITHIN ONE DAY PRE OP RANGE.
0846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE
0847	PROCEDURE IS A BILATERAL OR DUPLICATE
0848	PLEASE PAY SPECIFIED PROCEDURE CODES.
0849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON.
0850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE.
0851	PROCEDURE CODE IS INVALID FOR PATIENTS SEX.
0852	GMIS - INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE.
0853	PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS
0854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS.
0855	KYCONV-DESCRIPTION NOT FOUND
0856	PROCEDURE NOT INDICATED FOR A MALE
0857	PROCEDURE NOT INDICATED FOR A FEMALE
0858	CLAIM DENIED. COSMETIC PROCEDURE.
0859	CLAIM DENIED. DUPLICATE PROCEDURE.
0860	CLAIM DENIED. EXPERIMENTAL PROCEDURE.
0861	CLAIM DENIED. OBSOLETE PROCEDURE.
0863	PROCEDURE CODES DOES NOT REQUIRE AN ASSTANT SURGEON

CODE	DESCRIPTION
0864	PROCEDURE CODE IS INVALID FOR LOCATION.
0865	PROCEDURE CODE NEEDS TO BE REPLACED.
0866	PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED.
0867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED.
0868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS
0873	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF \$400.00 PER CALENDAR YEAR HAS
0874	CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF \$200.00 PER CALENDAR YEAR HAS
0875	CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF \$1500.00 PER
0876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO \$800.00 PER EAR, PER
0877	CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE
0878	CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS
0879	CLAIM DENIED. PROCEDURE REQUIRES DOCUMENTATION
0880	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14
0881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.
0882	CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID
0883	CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID.
0884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL
0885	CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE.
0886	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE BILLED.
0888	GMIS-VISIT IS WITHIN THE POST OP RANGE.

CODE	DESCRIPTION
0889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTA
0890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF TH
0891	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF
0893	UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT.
0894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.
0896	CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT.
0897	CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS.
0898	TOO MANY CLAIMS IN A CYCLE.
0899	DENIED PER PROVIDER REQUEST.
0900	THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESU
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR C
0902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES.
0903	CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID.
0904	CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE.
0905	CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, P
0906	PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FIL

CODE	DESCRIPTION
0907	CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE.
0908	CLAIM/DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERV
0909	CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.
0910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.
0911	MODIFIER INVALID FOR PROCEDURE CODE BILLED.
0912	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED.
0913	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWE
0914	CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED.
0915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED
0916	EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS
0917	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE.
0918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN TH
0919	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER
0920	CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES.
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR
0922	THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM

CODE	DESCRIPTION
0923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PAT
0924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6THB
0925	CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DA
0926	CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS V
0927	CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED.
0928	DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED.
0929	CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DAT
0930	CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT PO
0931	CLAIM DENIED. COMPOUND CODE MISSING OR INVALID.
0932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR
0933	CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID.
0934	CLAIM DENIED DUE TO TRANSITION TO NEW SYSTEM. PLEASE RESUBMIT CLAIM.
0935	DRUG INCOMPATABILITY ALERT.
0936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S)
0937	CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD.
0938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED
0939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED

CODE	DESCRIPTION
	PER
0941	CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE.
0942	CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENU
0943	CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2
0944	LOW DOSE ALERT.
0945	HIGH DOSE ALERT.
0946	LATE REFILL.
0947	MINIMUM DURATION ALERT.
0948	MAXIMUM DURATION ALERT.
0949	DRUG ALLERGY ALERT.
0950	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMEN
0951	THIS SERVICE IS NOT COVERED BY MEDICAID.
0952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT.
0953	CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER.
0954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
0955	CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT.
0956	THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE.
0957	CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCE
0958	EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST

CODE	DESCRIPTION
0959	PRIOR ADVERSE DRUG REACTION.
0960	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION R
0961	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE REVENUE CODE 10
0962	PREGNANCY ALERT.
0963	DRUG/GENDER ALERT.
0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYA
0965	CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO M
0966	CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBER
0967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF S
0968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SE
0969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NU
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIEL
0971	LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID.
0972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE
0973	PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DETAIL.
0974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PRO
0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE

CODE	DESCRIPTION
	GINGIVECTOMY PROCEDURE
0976	PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY.
0977	TYPE OF BILL INVALID FOR PROVIDER TYPE.
0978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.
0979	CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTE
0980	COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO
0981	CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR C
0982	CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 F
0984	MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE
0985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.
0986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE
0987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF
0988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE A
0989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.
0990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRT
0991	KYCONV-DESCRIPTION NOT FOUND
0992	DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13.

CODE	DESCRIPTION
0993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBUL
0994	CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE
0996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID.
0997	CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN AD
0998	CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED.
0999	PENDING FOR REVIEW.
1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON F
1001	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCAT
1002	COB - PAYER
1003	INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCAT
1006	FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP.
1011	INTERNAL ERROR
1016	NON-PARTICIPATING MANUFACTURER
1018	NO PRICING SEGMENT FOR LEVEL OF CARE
1037	FACILITY PROVIDER I.D. NOT ON FILE
1049	BILLING PROVIDER IS SUSPENDED OR TERMINATED.
1052	TAXONOMY CODE INVALID FOR RENDERING PROVIDER
1053	TAXONOMY CODE INVALID FOR PERFORMING PROVIDER

CODE	DESCRIPTION
1054	TAXONOMY CODE INVALID FOR BILLING PROVIDER
1055	DTL REFERRING PROV NOT ON FILE
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM
1059	THIS SERVICE IS NOT A VALID ENCOUNTER UNDER THE SOONERCARE CHOICE PROGRAM UNLES
1060	NO RENDERING PROVIDER FOR CROSSOVER CLAIM
1061	NO FACILITY PROVIDER FOR CROSSOVER CLAIM
1073	CROSSOVER MAY NOT BE SUBMITTED BY NON-CROSSOVER MEDICARE TRADING PARTNER
1106	THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE
1112	DETAIL DENIED. THE PROCEDURE BILLED HAS BEEN REBUNDLED TO A GLOBAL CPT-4 CODE
1117	CHRIS TEST
1118	THIS DRUG NOT COVERED BY MEDICARE PART D
1123	THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE
1129	DETAIL DENIED. PROCEDURE BILLED WAS PERFORMED WITH A PRIMARY PROCEDURE. ACCORDI
1606	MISSING OR INVALID PAYER DATE
1643	INVALID OTHER COVERAGE CODE
1652	MISSING OR INVALID OTHER PAYER COVERAGE TYPE
1800	Hard – Billing Atypical Provider Cannot Bill NPI (formerly Phase II 1900)
1801	Hard – Rendering Header Atypical Provider Cannot Bill NPI (formerly Phase II 1900)
1802	Hard – Referring Header Atypical Provider Cannot Bill NPI (formerly Phase II 1900)

CODE	DESCRIPTION
1804	Hard – Rendering Detail Atypical Provider Cannot Bill NPI (formerly Phase II 1901)
1805	Hard – Referring Detail Atypical Provider Cannot Bill NPI (formerly Phase II 1901)
1806	Hard – Billing Atypical Provider Number not Eligible for Date of Service
1807	Hard – Rendering Atypical Provider Number not Eligible for Date of Service
1808	Hard – Referring Atypical Provider Number not Eligible for Date of Service
1811	Hard – Rendering Provider Atypical Number not Eligible for Date of Service
1812	Hard – Referring Provider Atypical Number not Eligible for Date of Service
1814	Hard – Billing Provider Submitted Legacy Number Not Supported
1815	Hard – Header - Rendering Provider Submitted Legacy Number Not Supported
1816	Hard – Header - Referring Provider Submitted Legacy Number Not Supported
1818	Hard – Header – Other Provider 2 Submitted Legacy Number Not Supported
1819	Hard – Detail - Rendering Provider Submitted Legacy Number Not Supported
1820	Hard – Detail – Referring Provider Submitted Legacy Number Not Supported
1821	Hard – Detail – Other Provider 2 Provider Submitted Legacy Number Not Supported
1822	Suspend – Header - Rendering Provider – Billing Provider Not Found – Not on File (formerly Phase II 1914)
1823	Suspend – Header - Referring Provider – Billing Provider Not Found – Not on File (formerly Phase II 1914)
1825	Suspend – Header – Other Provider 2 – Billing Provider Not Found – Not on File (formerly Phase II 1914)
1826	Suspend – Detail - Rendering Provider – Billing Provider Not Found – Not on File (formerly Phase II 1915)
1827	Suspend – Detail - Referring Provider – Billing Provider Not Found – Not on File (formerly Phase II 1915)

CODE	DESCRIPTION
1828	Suspend – Detail - Other Provider 2 – Billing Provider Not Found – Not on File (formerly Phase II 1915)
1829	Hard – Header – Rendering Provider – Billing Provider Found – Not on File (formerly Phase II 1916)
1830	Hard – Header – Referring Provider – Billing Provider Found – Not on File (formerly Phase II 1916)
1832	Hard – Header – Other Provider 2 – Billing Provider Found – Not on File (formerly Phase II 1916)
1833	Hard – Detail – Rendering Provider – Billing Provider Found – Not on File (formerly Phase II 1917)
1834	Hard – Detail – Rendering Provider – Billing Provider Found – Not on File (formerly Phase II 1917)
1835	Hard – Detail – Other Provider 2 – Billing Provider Found – Not on File (formerly Phase II 1917)
1836	Hard – Billing Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1910)
1837	Hard – Rendering Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1910)
1838	Hard – Referring Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1910)
1840	Hard – Other 2 Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1910)
1841	Hard – Rendering Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1911)
1842	Hard – Referring Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1911)
1843	Hard – Other 2 Provider NPI not Eligible for Claim Date of Service (formerly Phase II 1911)
1844	Hard – Header – Billing Provider Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1902)

CODE	DESCRIPTION
1845	Hard – Header – Rendering Provider Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1902)
1846	Hard – Header – Referring Provider Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1902)
1848	Hard – Header – Other Provider 2 Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1902)
1849	Hard – Detail – Rendering Provider Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1903)
1850	Hard – Detail – Referring Provider Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1903)
1851	Hard – Detail – Other Provider 2 Match to Legacy 1 to 1 – Legacy Not Eligible for Submitted Date Of Service (formerly Phase II - NPI Only on Claim – 1903)
1852	Warning – Billing Provider Taxonomy Invalid (formerly Phase II – 1912)
1853	Warning – Rendering Provider Taxonomy Invalid (formerly Phase II – 1912)
1854	Warning – Referring Provider Taxonomy Invalid (formerly Phase II – 1912)
1856	Warning – Rendering Provider Taxonomy Invalid (formerly Phase II – 1913)
1857	Warning – Billing Provider Taxonomy Code Not Valid for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1924)
1858	Warning – Rendering Provider Taxonomy Code Not Valid for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1924)
1859	Warning – Referring Provider Taxonomy Code Not Valid for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1924)
1861	Warning – Rendering Provider Taxonomy Code Not Valid for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1925)
1862	Warning – Billing Provider Not Valid for Taxonomy Code for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1926)
1863	Warning – Rendering Provider Not Valid for Taxonomy Code for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1926)

CODE	DESCRIPTION
1864	Warning – Referring Provider Not Valid for Taxonomy Code for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1926)
1866	Warning – Rendering Provider Not Valid for Taxonomy Code for Claim Date of Service (formerly Phase II - NPI Only on Claim – 1927)
1900	ATYPICAL PROVIDERS SUBMITTING NPI ONLY NOT SUPPORTED - PLEASE RESUBMIT CLAIM WI
1901	ATYPICAL PROVIDERS SUBMITTING NPI ONLY NOT SUPPORTED - PLEASE RESUBMIT CLAIM WI
1908	Billing Provider NPI Not on File
1909	AVAILABLE EOB NOT USED
1910	NPI ONLY SUBMITTED ON CLAIM AT HEADER - NPI IS NOT ELIGIBLE FOR THE DATES OF SE
1911	NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SE
1912	WARNING - SUBMITTED TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VAL
1913	WARNING - SUBMITTED TAXONOMY CODE AT DETAIL IS NOT A VALID CODE - CHECK FOR VAL
1914	HEADER PROVIDER NPI NOT ON FILE
1915	DETAIL PROVIDER NPI NOT ON FILE
1916	HEADER PROVIDER NOT ON FILE
1917	DETAIL PROVIDER NOT ON FILE
1918	Warning – Billing Provider Zip 5 Code not Matched
1919	Warning – Billing Provider Zip 5 + 4 Code not Matched
1920	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT HEADER - NPI ONLY MUST
1921	WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT DETAIL -

CODE	DESCRIPTION
	NPI ONLY MUST
1922	Warning – Service Facility Provider Zip 5 Code not Matched – M Only
1923	Warning – Service Facility Provider Zip 5 + 4 Code not Matched – M Only
1950	PROCEDURE INCLUDED IN BUNDLED RATE
1951	HCPC IS REQUIRED
1955	CLAIM/SERVICE DENIED. THE BILLING PROVIDER NPI AND TAXONOMY CODE SUBMITTED ON T
1956	CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI AND TAXONOMY CODE SUBMITTED ON
1957	CLAIM/SERVICE DENIED. THE FACILITY PROVIDER NPI AND TAXONOMY CODE SUBMITTED ON
1958	CLAIM/SERVICE DENIED. THE OTHER PROVIDER NPI AND TAXONOMY CODE SUBMITTED ON THE
1959	CLAIM/SERVICE DENIED. THE PERFORMING PROVIDER NPI AND TAXONOMY CODE SUBMITTED O
1960	CLAIM/SERVICE DENIED. THE DETAIL REFERRING PROVIDER NPI AND TAXONOMY CODE SUBMI
1961	CLAIM/SERVICE DENIED. THE DETAIL OTHER PROVIDER NPI AND TAXONOMY CODE SUBMITTED
1962	CLAIM/SERVICE DENIED. THE DETAIL PERFORMING PROVIDER NPI AND TAXONOMY CODE SUBM
1963	THE KENPAC PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE
1964	THE LOCKIN PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE
1966	Multiple Legacy Numbers – Need Taxonomy to Find Unique Legacy
1967	Multiple Legacy Number – Need Service Facility Zip 5 to Find Unique Legacy

CODE	DESCRIPTION
1968	Multiple Legacy Number – Need Service Facility Zip 5 + 4 to Find Unique Legacy
1969	Multiple Legacy Number – Need Billing Zip 5 to Find Unique Legacy
1970	Multiple Legacy Number – Need Billing Zip 5 + 4 to Find Unique Legacy
1971	WARNING - KY MEDICAID NUMBER SUBMITTED ON THE CLAIM HEADER DOES NOT MATCH THE C
1972	WARNING - KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DETAIL DOES NOT MATCH THE C
1995	MMIS FACILITY PROVIDER ID NOT ENROLLED
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM.
1997	THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICA
1999	BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT
2000	ERROR DISPOSITION SETUP IS INVALID
2001	MEMBER ID NUMBER NOT ON FILE.
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE.
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE.
2004	PROCEDURE INCLUDED IN COMBINED PROCEDURE
2005	PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH
2006	RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA
2007	PA NOT AUTHORIZED FOR DRUG THERCLASS 46 & 47
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE
2009	MEMBER INELIGIBLE ON DATE OF SERVICE.
2010	PRESCRIPTION REFILLED TOO SOON

CODE	DESCRIPTION
2011	CLAIM SUSPENDED. MULTIPLE ACTIVE PREVIOUS ID'S FOUND FOR MEMBER
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED
2013	EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE
2014	EXCEEDS MONTHLY CLINIC VISIT LIMITS
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED
2018	DIABETIC SUPPLIES LIMITS EXCEEDED
2019	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED
2021	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE
2023	DEALER LIMITS EXCEEDED
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS
2026	EXCEEDS EPSDT CLINIC LIMITS
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE
2031	EXCEPTION CODE 031
2032	MAXIMUM RENTAL PAYMENT

CODE	DESCRIPTION
2033	HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED
2036	ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION
2037	MAXIMUM PAYMENT MADE
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH
2039	TARGETED ULTRASOUND/AMNIOCENTESIS REVIEW
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED
2041	EXCEPTION CODE 041
2042	EXCEEDS ONCE PER MONTH LIMIT
2043	ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD
2044	PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV.
2045	EXCEPTION CODE 045
2046	EXCEPTION CODE 046
2047	EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT
2048	CONFLICTING DENTAL SERVICE SAME DAY
2049	EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH
2050	EXCEPTION CODE 050
2051	EXCEEDS 2 VISIT LIMIT
2052	NO LTC STAFFING SUBMITTED FOR SERVICE MONTH
2053	LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER
2054	PCS INELIGIBLE FOR CATEGORY OF SERVICE

CODE	DESCRIPTION
2055	2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED
2056	TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED
2057	OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED
2058	YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED
2059	EXCEPTION CODE 059
206	PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT
2060	EXCEPTION CODE 060
2061	EXCEPTION CODE 061
2062	EXCEPTION CODE 062
2063	EXCEPTION CODE 063
2064	EXCEPTION CODE 064
2065	EXCEPTION CODE 065
2066	EXCEPTION CODE 066
2067	EXCEPTION CODE 067
2068	EXCEPTION CODE 068
2069	EXCEPTION CODE 069
2070	2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH
2071	THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER
2072	PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS
2073	EXCEPTION CODE 073
2074	PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS
2075	EXCEPTION CODE 075

CODE	DESCRIPTION
2076	EXCEEDS YEARLY FAMILY PLANNING EXAM LIMIT
2077	EXCEPTION CODE 077
2078	PREVIOUSLY PAID ONE VISIT ON THIS DAY
2079	EXCEPTION CODE 079
2080	PREVIOUSLY PAID AUDITORY EXAM IN 12 MONTHS
2081	CHILDRENS DAYS EXCEEDED
2082	CHILDRENS DAYS EXHAUSTED
2083	CHILDRENS VISITS EXCEEDED
2084	CHILDRENS VISITS EXHAUSTED
2085	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2086	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2087	TB DRUG
2088	EXCEPTION CODE 088
2089	EXCEPTION CODE 089
2090	PCS - 1500
2092	ALIEN-NO REQUEST FOR AUTHORIZATION RECEIVED
2095	REVIEW INVALID CARRIER DENIED BATCH
2096	DDSD HAS DENIAL/SUSPEND EDIT
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT
2099	MANUALLY SUSPEND FOR HCA
2101	ADP WAIVER HAS DENY/SUSP EDIT
2103	PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE

CODE	DESCRIPTION
2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE
2105	INVALID DIAGNOSIS FOR PROCEDURE
2106	MEMBER NAME IS MISSING
2110	PCS CLAIM - MEMBER NOT PCS ELIGIBLE
2112	MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS
2114	OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW
2115	VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD
2116	EXCEPTION CODE 116
2117	2 YEAR RESUBMISSION DEADLINE EXCEEDED
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE
2119	DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD
2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER
2122	INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER
2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER
2124	MISSING FIRST DATE OF SERVICE ON CLAIM
2125	ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
2127	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV
2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV
2129	MISSING MEMBER ID NUMBER ON CLAIM
2130	EXCEPTION CODE 130

CODE	DESCRIPTION
2132	MISSING TOTAL CLAIM CHARGE
2133	INVALID TOTAL CLAIM CHARGE
2134	INVALID NET CLAIM CHARGE
2136	MISSING/INVALID REVENUE CODE
2138	MISSING/INVALID TYPE OF BILL
2140	HCPC CODE IS INVALID FOR REVENUE CODE
2141	TOTAL DAYS LESS THAN COVERED DAYS
2142	1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED
2143	REFILLS EXHAUSTED
2144	INVALID REFILL INDICATOR VALUE
2146	HCPC/REVENUE CODE MISSING
2147	DIAGNOSIS NOT COVERED FOR THIS CLAIM TYPE FOR MEMBER'S BENEFIT PLAN
2148	PROCEDURE NOT PAYABLE THIS MEMBER
2149	PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER
2150	UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS
2151	MISSING PRESCRIBING PROVIDER NUMBER
2152	MISSING DRUG CODE
2153	INVALID DRUG CODE
2154	MISSING PRESCRIPTION NUMBER
2155	MISSING DRUG QUANTITY
2156	MISSING DAYS SUPPLY

CODE	DESCRIPTION
2160	MISSING DIAGNOSIS INDICATOR
2163	MISSING DIAGNOSIS CODE
2166	MEMBER ELIGIBILITY PENDING DHS APPROVAL
2167	INVALID PATIENT STATUS
2168	INVALID SOURCE OF ADMISSION
2170	INVALID PLACE OF SERVICE
2172	CLAIM REQUIRES HCPC OR CPT-4 CODE
2173	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE
2174	UNITS CANNOT BE LESS THAN DAYS
2175	SURGICAL PROCEDURE MISSING
2176	MEMBER NOT ON FILE PAY FROM STATE FUNDS
2178	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2179	MISSING TOOTH SURFACE
2180	INVALID TOOTH NUMBER
2181	INVALID TOOTH SURFACE
2182	MISSING TOOTH NUMBER
2183	MISSING UNITS OF SERVICE
2184	MISSING CHARGE
2185	LTC MISSING ADMISSION DATE
2186	INVALID ADMISSION HOUR
2187	PROCEDURE NOT PAYABLE THIS MEMBER
2189	PROCEDURE REQUIRES MEDICAL REVIEW

CODE	DESCRIPTION
2190	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2191	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM
2192	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
2193	MISSING COVERED DAYS
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES
2196	MISSING ADMISSION DATE
2197	INVALID INPATIENT REVENUE CODE
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2201	PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE
2203	CLAIMANT SIGNATURE MISSING
2204	PROVIDER SIGNATURE IS MISSING
2205	PATIENT NOT CERTIFIED
2206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT
2207	INVALID LEVEL OF CARE
2208	INVALID PICKUP LOCATION
2209	INVALID DESTINATION
2210	FACILITY PROVIDER SERVICE LOCATION IS MISSING
2213	PREGNANCY INDICATOR INVALID
2214	DATE PRESCRIBED IS INVALID

CODE	DESCRIPTION
2215	DATE DISPENSED IS MISSING
2216	DATE DISPENSED IS INVALID
2222	MISSING OCCURRENCE DATE
2223	SERVICE DATES ARE NOT IN SAME MONTH
2224	INVALID OCCURRENCE DATE
2226	INVALID CONDITION CODE
2227	EXCEPTION CODE 227
2228	MISSING MEDICARE PAID DATE
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
2231	ESTIMATED DAYS SUPPLY INVALID
2233	INSURANCE DENIAL REQUIRED
2234	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2235	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE
2237	FACILITY PROVIDER NOT IN VALID FORMAT
2238	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2239	INVALID OCCURRENCE CODE
2240	THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING.
2242	MISSING OCCURRENCE CODE
2244	INVALID PAY-TO PROVIDER NUMBER
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
2249	CLAIM HAS NO DETAILS

CODE	DESCRIPTION
2250	MEMBER IS NOT ON ELIGIBILITY FILE
2252	MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES
2253	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2254	MEMBER NOT IN MANAGED CARE
2258	MEMBER IS NOT ON ELIGIBILITY FILE
2259	DATE BILLED IS INVALID
2260	SLIMB ONLY/NO MEDICAL ELIGIBILITY
2262	PROCEDURES NOT PAYABLE TB
2263	PROCEDURE REQUIRES REVIEW FOR TB MEMBER
2265	CLAIM HAS THIRD-PARTY PAYMENT
2266	REFERRING PHYSICIAN NUMBER IS MISSING
2270	INPATIENT TB NOT COVERED
2271	MEMBER IS NOT ELIGIBLE ON SERVICE DATE
2272	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2273	SUSPENDED FOR MEMBER REVIEW
2274	CLAIM INDICATES MEMBER EXPIRED
2276	NEWBORN-HCA REVIEW
2277	LTC ELIGIBILITY ERROR
2278	DISCHARGE DTE UNEQ TO LTC ELIG
2281	ABORTION NOT COVERED
2282	PHYSICIAN AUDITOR REVIEW-MODIFIER 24
2285	MEMBER NOT ELIGIBLE FOR DATES OF SERVICE

CODE	DESCRIPTION
2287	PROCEDURE NOT PAYABLE VR
2289	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2290	PROCEDURE IS NOT IN THE SCOPE OF THE PROGRAM
2291	PROCEDURE REQUIRES MEDICAL REVIEW
2292	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2294	PROC REQUIRES REVIEW - HCBW
2295	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2296	PROVIDER INELIGIBLE FOR PROCEDURES
2297	PAY TO PROVIDER NOT ELIG FOR PAY-THIS DATE OF SERV
2298	PROVIDER NUMBER IS A GROUP NUMBER
2300	NO PROVIDER MASTER RECORD
2302	PRESCRIBING PROVIDER NOT ON FILE
2303	PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED.
2304	PROVIDER INELIGIBLE ON SERVICE DATE
2305	REVIEW CLAIMS FOR THIS PROVIDER
2306	PAY TO PROVIDER IS SUSPENDED
2307	BILLING OUT OF CLIA CERTIFICATE TYPE
2308	NO PAY-TO PROVIDER RECORD
2309	REVIEW CLAIM FOR PAY-TO- PROVIDER
2310	ANESTHESIA MODIFIER IS INVALID OR MISSING
2311	SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP
2312	PAY-TO PROVIDER NOT ENROLLED

CODE	DESCRIPTION
2313	DIAGNOSIS CODE MISSING/NOT ON FILE
2314	SURGICAL PROCEDURE CODE NOT FOUND
2315	INVALID PRINCIPAL/OTHER PROCEDURE TYPE
2316	ATTACHMENT CONTROL NUMBER MISSING
2317	INVALID/MISSING MODIFIER FOR THIS PROCEDURE
2318	PROCEDURE REQUIRES MANUAL PRICING
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED
2321	PROCEDURE CODE IS NO LONGER VALID
2322	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE
2323	INVALID MEMBER AGE FOR THIS DIAGNOSIS
2324	INVALID MEMBER SEX FOR THIS DIAGNOSIS
2326	INVALID TOOTH NUMBER FOR THIS PROCEDURE
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION
2328	PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE
2329	INVALID MEMBER SEX FOR THIS PROCEDURE
2331	THIS DRUG NOT COVERED FOR THE MEMBER
2332	INVALID PROVIDER TYPE FOR THIS PROCEDURE
2335	LTC MEMBER - NONCOMP DRUG
2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2338	LTC DRUG ONLY
2341	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW

CODE	DESCRIPTION
2342	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2345	ATTENDING PROVIDER NOT FOUND
2346	REFERRING PROVIDER NOT FOUND
2347	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2348	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
235	PROCEDURE CODE NOT IN VALID FORMAT
2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.
2351	SUBMITTED TO ALLOWED EXCEEDS PERCENT
2352	ALLOWED TO SUBMITTED EXCEEDS PERCENT
2354	THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE
2356	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2357	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2358	INACTIVE DRUG
2359	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2360	THIS NATIONAL DRUG CODE IS NOT ON FILE
2361	PROCEDURE CODE IS MISSING/NOT ON FILE
2362	MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM
2366	THIS DIAGNOSIS REQUIRES REVIEW
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY
2374	MISSING PRESCRIBER PROVIDER ON DEALER CLAIM

CODE	DESCRIPTION
2375	SERVICE NOT ON EXPLANATION OF MEDICARE PAYMENTS
2377	MEMBER IS INELIGIBLE FOR THIS DRUG
2379	PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW
2383	MULTIPLE SURGERY REQUIRES REVIEW
2385	REVENUE CODE NOT ON FILE
2388	IMPROPER MODIFIER FOR CRNA
2389	THIS MODIFIER IS ALLOWED FOR CRNA ONLY
2390	MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE
2391	INVALID USE OF E DIAGNOSIS CODE
2394	VERIFY PCS TPL
2396	LOC ON CLAIM CONFLICTS WITH LOC ON FILE
2397	INVALID LTC TERMINATION CODE
2399	REFERRING PROVIDER I.D. # IS NOT IN A VALID FORMAT
2400	INVALID LOC DAYS
2401	INVALID LEAVE DAYS
2402	INVALID TYPE OF LEAVE
2406	LTC LEAVE DATES CONFLICT
2407	THERAPEUTIC DAYS GT THAN 14
2410	PA IS REQUIRED
2411	THERAPEUTIC DAYS USED EXCEEDS AUTHORIZATION
2412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
2413	LTC BLOCK 13:TOTAL DAYS DO NOT EQUAL FROM/TO DAYS

CODE	DESCRIPTION
2414	WAIVER SERVICES LONG TERM CARE CONFLICT
2416	AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE
2417	REVIEW AMBULANCE NON ROUTINE DESTINATION
2420	THIS DRUG NOT PAYABLE FOR MEMBER AGE
2421	THIS DRUG NOT PAYABLE FOR MEMBER SEX
2425	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE
2430	LTC INVALID MEMBER ID NUMBER
2431	LTC NO PROV MASTER RECORD
2433	LTC MISSING PROVIDER NUMBER
2434	LTC INVALID PROV NUM CK-DIGIT
2435	LTC FIRST DATE OF SERVICE MISSING
2436	LTC FILING DEADLINE EXCEEDED
2437	LTC FIRST DATE GREATER LAST DATE
2438	LTC RECHECK SERVICE DATE
2439	LTC MISS MEMBER ID NUMBER
2443	LTC MEMBER NOT ON ELIG FILE
2444	LTC MEMBER INELIGIBLE ON SERVICE DATES
2445	LTC MEMBER NOT ELIGIBLE ON SERVICE DATES
2446	LTC MEMBER SUSPEND FOR REVIEW
2447	LTC PROV IS SUSPENDED
2448	LTC PROVIDER IS INELIGIBLE ON SERVICE DATES
2449	LTC REVIEW CLAIM FOR PROV

CODE	DESCRIPTION
2450	INVALID QUADRANT
2451	LTC INV PROVIDER NUMBER
2452	RENDERING PROVIDER SERVICE LOCATION IS MISSING
2453	INVALID DIAGNOSIS TREATMENT INDICATOR
2454	INVALID ASSIGNMENT CODE
2456	INVALID PROCEDURE TYPE
2458	ALIEN MEMBER ON REVIEW
2459	REVENUE CODES OP401 & OP403 NEED HCPC CODE
2460	CANNOT DETERMINE THE INPATIENT LEVEL OF CARE
2461	OCCURENCE CODE SPAN MISSING/INVALID
2462	INVALID/MISSING SPAN DATE
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE
2464	SPAN DATE CONFLICT WITH DATES OF SERVICE SHOWN
2465	SPAN DATES OVERLAP
2466	SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS
2468	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2469	LTC MEMBER NAME/ID MISMATCH
2470	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2471	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2472	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2473	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2474	DATE DISPENSED AFTER BILLING DATE

CODE	DESCRIPTION
2475	DATE DISPENSED AFTER ICN DATE
2476	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID
2477	THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT
2478	PCS MISSING SUBMITTED CHARGE
2479	CLIA OUT OF DATE
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
2486	INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION
2487	PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE
2489	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2490	INPATIENT SERVICES ARE NOT COVERED FOR THIS MEMBER
2491	DRUG NOT APPROVED
2492	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2493	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2494	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2495	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2496	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2497	NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE
2498	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2499	TPL PAY CHASE IMMUNO SUPPRESS DRUG
2500	TPL - PAY AND REPORT
2501	SUSPEND FOR TPL REVIEW

CODE	DESCRIPTION
2502	FILE CLAIM WITH MEDICARE
2503	THIS PATIENT HAS OTHER INSURANCE
2505	CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR
2507	EPSDT-MAY HAVE TPL
2508	TPL PAY AND CHASE PHARMACY
2509	TPL PAY AND CHASE PRE-NATAL
2510	THIS PATIENT HAS TWO COVERAGE TYPES
2518	PROVIDER TYPE - CLAIM INPUT CONFLICT
2519	DRUG REQUIRES PRIOR AUTHORIZATION
2520	DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED
2522	MEMBER IS NOT ELIGIBLE FOR THESE SERVICES
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE
2526	PCS PRIOR AUTHORIZATION NOT ON FILE
2527	PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES
2528	PCS PRIOR AUTHORIZATION UNITS USED
2530	TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE
2532	DISEASE STATE MANAGEMENT
2533	PDUR DRUG-ALLERGY INTERACTION
2534	PRODUR DRUG-AGE INTERACTION
2535	PDUR INGREDIENT DUPLICATION
2536	PDUR THERAPEUTIC DUPLICATION

CODE	DESCRIPTION
2537	PDUR DRUG-TO-DRUG INTERACTION
2538	HMO CO-PAY/MEMBER HAS TPL
2539	PDUR EARLY REFILL ON PRESCRIPTION
2540	PDUR MINIMUM DURATION OF THERAPY
2541	PDUR DOSING PRECAUTION-HIGH DOSE
2542	PDUR DOSING PRECAUTION-LOW DOSE
2543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION
2544	PDUR MAXIMUM DURATION OF THERAPY
2545	PDUR LATE REFILL ON PRESCRIPTION
2546	DRUG DISEASE MARKER
2547	HMO CO-PAY/MEMBER HAS MEDICARE
2548	PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP
2549	ADJUSTMENT SUSPEND FOR MANUAL REVIEW
2550	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
2552	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID
2555	CLAIM PAST 24 MONTH FILING - DTL
2556	MEMBER IS NOT WAIVER ELIGIBLE
2557	CLAIM PAST 24 MONTH FILING - HDR
2560	MEMBER SERVICES COVERED BY HMO PLAN
2561	PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY
2562	MEMBER PCPCM-CANNOT BILL OP/RHC/FQHC CLINICS RATE
2563	MEMBER NOT ENROLLED IN HMO FOR DOS

CODE	DESCRIPTION
2564	SUPPLEMENTAL DELIVERY PYMT DENIAL CODE
2566	EXCEPTION CODE 566
2567	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE
2569	CC CLAIMS CAN'T PROCESS THRU SYSTEM
2570	INVALID ELIGIBILITY FOR HMO COPAY
2571	CLAIMCHECK REBUNDLED
2572	CC INCIDENTAL TO PRIMARY PROCEDURE
2573	CC MUTUALLY EXCLUSIVE
2574	CLAIMCHECK COSMETIC SURGERY
2575	CLAIMCHECK DUPLICATE
2576	CC UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED
2577	CLAIMCHECK POSSIBLE DUPLICATE
2578	CLAIMCHECK PRE-OP/POST-OP
2579	CC GROUPEALTH SMARTSUSPENSE SUSPEND
2580	CLAIMCHECK MEDICAL/EVALUATION VISIT
2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
2582	MEMBER IS LOCKED-IN TO ANOTHER PHARMACY
2583	CLAIMREVIEW NEW VISIT FREQUENCY
2584	CC GROUPEALTH SMARTSUSPENSE DENY
2587	CLAIMREVIEW INTENSITY OF SERVICE
2588	STOP LOSS NOT APPROVED
2589	CC INVALID MODIFIER/PROCEDURE COMBINATION

CODE	DESCRIPTION
2590	CLAIMCHECK EXCEEDS 40 LINES
2591	CLAIMREVIEW MULTIPLE/DUPLICATE COMP.BILLING
2592	CLAIMCEHCK AGE REPLACEMENT
2593	CLAIMREVIEW DIAGNOSIS TO PROCEDURE
2594	CLAIMCHECK-BILL EACH DOS ON A SEPARATE LINE
2595	CLAIMCHECK AGE CONFLICT
2597	CLAIMCHECK MULTIPLE SURGERY
2598	CC-MULTIPLE SURGERY-DOUBLE MODIFIERS
2599	STOP LOSS THRESHOLD REACHED
2600	UNITS NOT EQUAL TO TEETH BILLED
2601	PART A CROSSOVER SPANS 20020501
2602	UNITS NOT EQUAL TO TEETH BILLED
2603	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2604	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2605	PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH
2606	PRIOR AUTH UNITS/AMOUNTS USED
2609	CHECK CLAIM ATTACHMENT
2612	TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA
2614	DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS
2615	CLINIC RATE NOT ON FILE FOR HOSPITAL
2616	PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON
2618	AUTH SERVICES-MEMBER NOT ELIG

CODE	DESCRIPTION
2619	MEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND
2620	MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM
2622	MASS CREDIT/ADJ BEING SUSPEND
2623	ADJUSTMENT HAS AUTO DENIAL
2625	FUND CODE UNDETERMINED
2627	COVERED FOR ORAL PATH ONLY
2628	DRUG REQUIRES PRIOR AUTHORIZATION/MN
2630	DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM
2631	DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM
2632	DIAGNOSIS NOT IN SCOPE OF CN PROGRAM
2633	DIAGNOSIS NOT IN SCOPE OF MN PROGRAM
2634	DETAIL ATTENDING PHYSICIAN ID INVALID
2635	DETAIL FIRST OTHER PHYSICIAN ID INVALID
2636	DETAIL SECOND OTHER PHYS ID INVALID
2638	DRUG REQUIRES MEDICAL REVIEW/CN
2639	DRUG REQUIRES MEDICAL REVIEW/MN
2642	INVALID PROVIDER NUMBER
2643	ABORTION REQUIRES REVIEW
2644	PROCEDURE CODE MODIFIER NOT PAYABLE
2646	PROVIDER RATE NOT ON FILE
2648	CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE
2649	FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS

CODE	DESCRIPTION
2651	INVALID TREATMENT DIAGNOSIS INDICATOR
2652	PCS-INVALID NET CLAIM CHARGE
2653	MEMBER ID IS INVALID FOR AUTH EXAM
2654	MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD
2655	ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH
2657	POTENTIAL DISABILITY CLAIM
2659	DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD
2660	ZERO AMOUNT TO PAY
2673	SUBMIT PAPER CLAIM
2681	PROVIDER INELIGIBLE ON DATE OF SERVICE
2696	CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY
2697	QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY
2701	PHYSICAN SIGNED CONSENT FORM BEFORE STERILIZATION
2702	DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM
2703	MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM
2704	REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION
2705	STERILIZATION CONSENT FORM IS NOT LEGIBLE
2706	DATE ON THE CONSENT FORM IS NOT LEGIBLE
2707	STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING
2708	PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM
2709	CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION
2710	CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION

CODE	DESCRIPTION
2711	STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN
2712	CONSENT FORM IS NOT SIGNED BY THE MEMBER
2713	CONSENT FORM IS NOT SIGNED BY THE COUNSELOR
2714	CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED
2715	STERILIZATION CONSENT FORM IS INCOMPLETE
2716	HYSTERECTOMY CONSENT FORM REQUIRED
2717	STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN
2718	INVALID SURGICAL PROCEDURE CODE
2719	REFILE CLAIM WITH OPERATIVE REPORT
2720	INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM
2721	FURTHER DESCRIPTION OF SERVICE REQUIRED
2722	STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ
2723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY
2724	REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES
2725	SERVICE NOT COVERED AS BILLED
2726	REFERRING PHYSICIAN REQUIRED
2727	ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES
2728	SERVICES ARE NOT AUTHORIZED
2729	DENIED AFTER SPECIAL REVIEW
2730	HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY
2732	COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER
2733	SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM

CODE	DESCRIPTION
2734	PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION
2735	MEMBER INELIGIBLE ON SERVICE DATES
2736	MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW
2737	INVALID MODIFIER FOR THIS PROCEDURE
2738	INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE
2739	ONE AMBULATORY SURGERY ALLOWED PER DAY
2740	INVALID CODE FOR NARRATIVE DESCRIPTION
2741	INVALID SUBMITTED CHARGE
2742	AUTHORIZED PHYSICAL REQUIRES ABCDM-16
2743	EXCEPTION CODE 743
2744	AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16
2745	REQUESTED ADDITIONAL INFORMATION NOT RECEIVED
2746	DENTAL X-RAYS ARE REQUIRED
2747	SERVICES ARE INCLUDED IN TOTAL PAID OB CARE
2748	PROCEDURE IS AN INCIDENTAL TO PAID MAJOR SURGERY
2749	OUTSIDE THE GUIDELINES OF THE MEDICAL PROGRAM
2750	EXCEEDS SUPPLY LIMIT/1 MONTH WITHIN 12 MONTHS
2751	EXCEPTION CODE 751
2752	PER PHY MANUAL-USE 99202 ANTEPART WHEN NOT TOT. OB
2753	PROCEDURE IS INCIDENTAL MAJOR PROCEDURE ON CLAIM
2754	REFILE USING "MEMBER AREA" IN SQ CM
2755	REFILE CLAIM WITH PROOF OF TIMELY FILING ATTACHED

CODE	DESCRIPTION
2756	EXCEPTION CODE 756
2757	TAKE HOME MEDICATION IS NOT PAYABLE
2758	PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER
2759	NEEDS COUNTY ADMIN AND/OR PROVIDER SIGNATURE
2760	MEMBER IS DECEASED THIS DATE OF SERVICE
2761	NAME ON SUBMITTED CLAIM DOES NOT MATCH DHS FILE
2762	FILE AN ASSIGNED MEDICARE CLAIM ON THIS PATIENT
2763	PCS - HEALTH CARE AUTHORITY WILL PROCESS CLAIM
2764	DUPLICATE OF PAID CLAIM
2765	INVALID HYSTERECTOMY CONSENT FORM
2766	STERILIZATION/HYSTERECTOMY CONSENT FORM IS INVALID
2767	EXCEPTION CODE 767
2768	REQUEST ADJUSTMENT TO PAID CLAIM-PER MANUAL
2769	PAYMENT CORRECTED/SPENDDOWN-ADM12-HIST ONLY ADJUST
2770	INSURANCE PAYMENT MORE THAN ALLOWABLE
2771	SERVICE NOT PAYABLE THIS DATE OF SERVICE
2772	TYPE OF BILL-CLAIM CONFLICT
2773	AUTHORIZED ROOM & BOARD SERVICES ARE NOT ON CLAIM
2774	EXCEPTION CODE 774
2775	CLAIM HAS BEEN FORWARDED TO HCA
2777	SHOW MEDICARE PART B PAYMENTS
2778	HEALTH CARE AUTHORITY PROCESSED ADM12

CODE	DESCRIPTION
2779	ELIGIBILITY PROBLEM PROCESSED BY DHS
2780	RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS
2781	ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH
2782	PART OF INPATIENT HOSPITAL CHARGES
2783	PROCEDURE INCLUDED IN OFFICE CALL
2785	ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION
2786	SAME NDC/DATE PAID THIS PHARM
2787	ASST SURGEON MUST FILE OWN CLM
2788	CLINIC VISIT PAID THIS DATE
2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN
2790	ABCDM-16/CLAIM PROV CONFLICT
2791	INVALID DIAGNOSIS FOR DESCRIPTION
2792	STERILIZATION CONSENT REQUIRED
2793	SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE
2794	PAID CLAIM INCLUDED THIS PROCEDURE
2795	CC MUTUALLY EXCLUSIVE
2796	PATIENT HAS PRIVATE INSURANCE
2797	MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS
2798	REFILE WITH MEDICARE RECHECK HIC NUMBER
2799	EXCEPTION CODE 799
2800	PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM
2801	PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM

CODE	DESCRIPTION
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM
2803	DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM
2804	DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2806	PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM
2807	PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2812	CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM
2813	EXCEPTION CODE 813
2814	CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM
2815	LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM
2816	LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2820	PCS-EXACT DUPLICATE OF ANOTHER CLAIM
2821	PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2822	EXCEPTION CODE 822
2823	OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2824	OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2826	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM
2827	EXCEPTION CODE 827
2828	HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM
2829	INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2830	INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2831	EXCEPTION CODE 831
2832	TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM

CODE	DESCRIPTION
2833	TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2835	CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM
2836	CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2838	LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM
2839	LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2842	DEALER-EXACT DUPLICATE OF ANOTHER CLAIM
2843	DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2845	OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM
2846	OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2849	INVALID MODIFIER COMBINATION
2850	LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM
2851	LTC-HOME HEALTH CLAIM CONFLICT
2852	LTC-PCS POSSIBLE CONFLICT
2853	PCS-LTC POSSIBLE CONFLICT
2854	INPATIENT-PCS POSSIBLE CONFLICT
2855	PCS-INPATIENT POSSIBLE CONFLICT
2856	HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM
2857	INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT
2858	INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM
2859	EXCEPTION CODE 859
2860	CROSS CLAIM TYPE J CODE CONFLICT
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK

CODE	DESCRIPTION
2880	PRODEDURE CODE NOT VALID FOR FORM
2881	HOME HEALTH-LTC CLAIM CONFLICT
2882	LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM
2883	CROSSOVER-PCS POSSIBLE CONFLICT
2884	PCS-CROSSOVER POSSIBLE CONFLICT
2889	PART-A COINSURANCE GREATER MEDICARE PD AMT
2890	REVIEW CROSSOVER PART B COINSURANCE OVER \$1000.00
2893	EXCEPTION CODE 893
2894	RURAL HEALTH REVENUE REQUIRES HCPC CODE
2895	RURAL HEALTH CLINIC REQUIRES REVENUE OP521
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
2900	PCS DAYS REDUCED-INPT/LTC CONFLICT
2901	FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS
2903	MULTIPLE CPT CODES REQUIRED
2904	DENIED FOR OKLA FOUNDATION FOR PEER REVIEW AUDIT
2905	REFILE SEPARATE CLAIM FOR EACH MONTH
2906	MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS
2907	PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE
2908	ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE
2909	FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER
2910	PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA
2911	SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT

CODE	DESCRIPTION
2912	CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW
2913	CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW
2914	SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM
2915	PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM
2916	EXCEPTION CODE 916
2917	CHARGES INDICATE ERROR IN MATH
2918	INDICATE UNITS WORKED NOT DAYS
2919	FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE
2920	WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION
2921	LIST EACH DATE SEPARATELY
2922	PATIENT RECEIVED SETTLE/BILL PATIENT
2923	ITEMIZE CHARGES FOR SUPPLIES
2924	CLIENT RESPONSIBLE EXCEEDS ALLOWABLE
2925	MEDICAL CONDITION/DIAGNOSIS NOT COVERED
2926	DME NAME BRAND DOES NOT MATCH ORDER NUMBER
2927	INDICATE EXACT UNITS PROVIDED FOR MEMBER
2928	WHOLESALE'S INVOICE REQUIRED FOR PAYMENT
2929	PROC/DIAG REQUIRE FEDERAL MANDATED STATMT-ABORTION
2930	PROCEDURE UNITS REDUCED TO ALLOWABLE
2931	EXCEPTION CODE 931
2932	DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM
2933	ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS

CODE	DESCRIPTION
2934	CLAIM WAS FILED WITH INVALID PROVIDER NUMBER
2935	RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH
2936	CONTACT CASE MANAGER OR SUPERVISOR
2937	PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE
2938	EXCEPTION CODE 938
2939	REFILE ON PAPER CLAIM
2940	SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING
2941	REFILE WITH MEDICARE REMITTANCE STATEMENT
2942	DUPLICATE PAID THRU FINANCE
2943	REFILE ON ADM84-TRANSPORTATION CLAIM FORM
2944	DENIED AFTER CLAIM CHECK REVIEW
2945	INVALID PROOF OF DENIAL/HMO
2946	INVALID PROOF OF INSURANCE DENIAL
2947	REFILE WITH CORRECT ADMIT DATE
2948	RESUBMIT LEGIBLE CLAIM/ATTACHMENT
2949	EXCEPTION CODE 949
2950	THIS LEVEL TRANSPORTATION NOT REQUIRED
2951	DDSD WILL PROCESS CLAIM THROUGH FINANCE
2952	REFILE-NAME BRAND & PRODUCT/ORDER NUMBER FOR PRICE
2953	REFILE AS CROSSOVER WITH EOMP
2954	REFILE WITH APPROPRIATE EOMP
2955	NOT ELIGIBLE FOR WAIVERED SERVICES

CODE	DESCRIPTION
2956	TPL PAID COLLECT FROM PATIENT
2957	NOT VERIFIED BY OPERATIVE REPORT
2958	ITEMIZE SURGERIES PER OPERATIVE REPORT
2959	CANNOT PROCESS NEGATIVE AMOUNTS
2960	ADJUSTED PER OFPR RECOMMENDATION
2961	NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN
2962	DOCUMENT OF NECESSITY/MRI REPORT REQUIRED
2963	DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE
2964	REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND
2965	PAY REMAINING DAYS ON PARAMETER FILE
2966	FILE MEDICARE PART A FOR INPATIENT SERVICES
2967	PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP
2968	REFILE AS PHARMACY WITH NATIONAL DRUG CODE
2969	NO MEDICAL JUSTIFICATION FOR TARGETED OB US
2970	SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION
2971	PARTIAL HOURS NON ACCEPTABLE
2972	NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL
2973	REFILE AS AMBULATORY SURGERY
2974	PRESCRIBING PROVIDER EXCLUDED
2976	HYSTERECTOMY REQUIRE SIGN DATE
2977	REFILE CLAIM WITH MEDICAL RECORD
2978	INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE

CODE	DESCRIPTION
2979	NURSING HOME CLAIMS PAID THIS DATE OF SERVICE
2980	PROCEDURE NOT PAYABLE FOR THIS AGE
2981	VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE
2982	REFILE WITH PHYSICIAN PROGRESS NOTES
2983	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2984	DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE
2985	PROVIDER IS SUSPENDED OR TERMINATED
2986	UNITS CANNOT BE GREATER THAN 999
2987	PRIOR AUTHORIZATION UNITS/AMOUNTS USED
2988	TB ONLY ELIGIBLE - NEED 'T' IN FORCE FIELD (FF)
2989	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2990	SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER
2991	UNITS REDUCED PER DOCU/AFTER SURS REVIEW
2993	EXCEPTION CODE 993
2994	EXCEPTION CODE 994
2995	EXCEPTION CODE 995
2996	EXCEPTION CODE 996
2997	EXCEPTION CODE 997
2998	EXCEPTION CODE 998
2999	EXCEPTION CODE 999
3000	UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTHORIZATION MASTER.
3001	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL.

CODE	DESCRIPTION
3003	SERVICE REQUIRES PRIOR AUTHORIZATION.
3006	DOLLARS EXCEED AUTHORIZED DOLLARS ON AUTHORIZATION MASTER.
3037	MEMBER NUMBER HAS BEEN DEACTIVATED
3301	TOTAL CLAIM BILLED EXCEEDS DOLLAR LIMIT (\$99,000)
3354	LTC PROVIDER NUMBER MUST BE ENTERED.
3360	TAXONOMY CODE INVALID
3362	PA NUMBER OR PA PAYMENT METHOD IS NOT VALID
3395	ANESTHESIA PROCEDURE LIMITED TO 15 UNITS
3600	SERVICE NOT COVERED UNDER MEMBER'S PROGRAM.
3999	CLAIM BILLED WITH INACTIVE RID
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM
4002	THIS NDC CODE IS NOT COVERED FOR THIS MEMBER.
4003	DRUG IS LESS THAN EFFECTIVE - DESI
4014	NO PRICING SEGMENT IS ON FILE.
4019	PROCEDURE CODE REQUIRES ATTACHEMENT.
4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE
4021	THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4026	NDC/DAYS SUPPLY LIMITATIONS. THIS NDC CODE BILLED MAY NOT BE GREATER THAN THE
4029	DIAGNOSIS AND PLACE OF SERVICE DO NOT MATCH FOR THE MEMBER'S BENEFIT PLAN
4031	GENDER RESTRICTION FOR BILLED DIAGNOSIS.
4033	INVALID PROCEDURE CODE MODIFIER COMBINATION

CODE	DESCRIPTION
4039	DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
4063	ICD*9 CM PROCEDURE CODE/AGE RESTRICTION.
4064	GENDER RESTRICTION FOR COVERED ICD*9.
4065	ICD*9 CM PROCEDURE REQUIRES ATTACHMENT.
4070	MODIFIER RESTRICTION FOR REIMBURSEMENT RULE
4077	REVENUE CODE INVALID FOR DATE OF SERVICE.
4089	MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL
4098	PRICING BEING REVIEWED
4107	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PRO
4108	NO ASC ON FILE
4114	PRICING BEING REVIEWED
4115	PRICING BEING REVIEWED
4119	VALUE CODE AMOUNT MISSING XYZ
4120	VALUE CODE IS MISSING
4121	PROCEDURE CODE REQUIRES TOOTH QUADRANT
4122	VALUE CODE IS INVALID
4123	VALUE CODE AMOUNT IS MISSING
4124	VALUE CODE AMOUNT IS INVALID
4127	CANNOT PRIORITIZE MEMBER'S PROGRAMS
4140	THIS PROVIDER MAY NOT BILL THIS SERVICE FOR THIS MEMBER.

CODE	DESCRIPTION
4141	THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4142	THIS REVENUE CODE IS NOT VALID FOR THIS PROVIDER CONTRACT.
4203	THIS SERVICE IS A NON-COVERED OKLAHOMA HEALTH COVERAGE PROGRAM SERVICE AS THE R
4207	CLIA NUMBER MISSING OR NOT ON FILE FOR DATE OF SERVICE.
4209	NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED
4211	PROCEDURE CODE/TOOTH NUMBER COMBINATION IS MISSING OR INVALID.
4215	REVENUE CODE NOT VALID FOR THIS BILL TYPE
4218	INVALID PROCEDURE FOR CLAIM FORM
4220	EPOGEN REQUIRES VALUE CODE 68
4227	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.
4244	THIS DIAGNOSIS IS NOT COVERED FOR THIS MEMBER.
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.
4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4253	REVENUE CODE REQUIRES MEDICAL REVIEW
4254	REVENUE CODE VS AGE RESTRICTION
4255	ONE OR MORE MODIFIERS ON THIS DETAIL CAN ONLY BE BILLED FOR MEMBERS AGED 21 AND
4257	THIS PROCEDURE CODE/MODIFIER COMBINATION IS NOT COVERED FOR THIS PROVIDER CONTR
4318	PRIMARY HEADER DX RESTRICTION FOR BILLED ICD*9 PROCEDURE.
4381	NO REIMBURSEMENT RULE ON FILE.

CODE	DESCRIPTION
4384	THE PRIMARY DIAGNOSIS ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT.
4385	MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE CODE
4386	PROVIDER CONTRACT - PROCEDURE NOT BILLABLE WITH REVENUE CODE
4387	REIMBURSEMENT - PROCEDURE NOT PAYABLE WITH REVENUE CODE
4391	THE LENGTH OF STAY ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT.
4393	CONTRACT INVALID REVENUE/PROCEDURE COMBO
4394	UNABLE TO DETERMINE REGULAR MEDICAID CLAIM TYPE FOR CROSSOVER CLAIM
4395	PROVIDER CONTRACT - PROCEDURE - OOS NOT COVERED
4396	PROVIDER CONTRACT - REVENUE CODE - OOS NOT COVERED
4397	PROVIDER CONTRACT - DRG - OOS NOT COVERED
4398	PROVIDER CONTRACT - ICD9 PROC - OOS NOT COVERED
4400	NDC NOT FOUND IN DRUG FILE.
4401	THIS NDC IS NOT VALID FOR THE DRUG GROUP FOR THIS PROCEDURE
4402	THIS NDC DRUG GROUP IS NOT VALID FOR THE PROCEDURE
4403	QTY BILLED FOR THE NDC IS 0
4404	AWP NOT ON FILE FOR NDC
4714	AGE RESTRICTION FOR BILLED PROCEDURE.
4760	MEDICAL REVIEW RESTRICTION FOR BILLED ICD*9.
4765	THIS ICD*9 PROCEDURE IS NOT COVERED FOR THIS MEMBER.
4801	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4802	THE PROVIDER IS NOT ALLOWED TO BILL THIS DIAGNOSIS

CODE	DESCRIPTION
4804	THIS REVENUE CODE IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4805	THIS DRG IS NOT COVERED FOR THIS PROVIDER CONTRACT.
4831	NO REIMBURSEMENT RULE ON FILE.
4882	THIS DRG IS NOT COVERED FOR THIS MEMBER.
4975	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER.
4990	THIS PROCEDURE CODE IS NOT COVERED FOR THIS MEMBER.
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT.
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL.
5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEAS
5005	REVERSAL NOT PROCESSED- MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER NU
5006	REVERSAL NOT PROCESSED, CLAIM OVER 60 DAYS - SUBMIT MANUAL ADJUSTMENT.
5007	THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJU
5010	EXACT DUPLICATE - TOOTH SURFACE
5100	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAVE BEEN PAID. NO ADDITIONAL VISITS WILL
5101	PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99213)
5102	PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99348)
5110	CLAIM DETAIL DENIED. MUST BILL INTRAORAL COMPLETE SERIES

CODE	DESCRIPTION
5200	VENI/ARTERIAL PUNCTURE SAME DATE OF SERVICE AS MONITORED PROCEDURE.
5203	CBC MAY NOT BE PAID ON SAME DAY AS CBC COMPONENTS.
5235	REV 580 & PROC S5100 NOT BILLABLE SAME DOS
5236	MONTHLY DIALYSIS NOT PAYABLE FOR SAME DATE OF SERVICE AS DAILY.
5241	PROCEDURES ARE NOT PAYABLE IN 30 DAYS OF RELATED PROCEDURES.
5269	09110/D9110 ON SAME DOS AS OTHER PROCEDURE.
5271	PAYMENT FOR PROCEDURE IS IN REIMBURSEMENT FOR SURGERY.
5272	PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE.
5278	GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL.
5290	S5100 AND S5101 NOT BILLABLE ON SAME MEMBER SAME DOS
5292	HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE.
5295	PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE
5302	PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWED ON SAME DATE OF SER
5400	MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH.
5422	PERI AND ROOT SCALING NOT ALLOWED SDOS AS PROPHY
5500	STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG
5632	LAP HYSTER NOT BILLABLE WITH OTHER HYSTER PROC
6200	MEMBERS ARE LIMITED TO ONE (1) OPHTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALE
6205	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER PER

CODE	DESCRIPTION
6210	99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR.
6211	99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR.
6514	HOME HEALTH LIMITS EXCEEDED FOR 1 MONTH
6554	WAIVER LIMIT FOR PHARMACY HAS BEEN REACHED
6660	THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED.
6661	PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMP
6700	FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE
6701	FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE
6702	FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE
6703	FOLLOW-UP VISITS NOT PAYABLE WITHIN 60 DAYS OF SURGICAL PROCEDURE
6704	FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE
6726	DENTAL PROPHY/FLUORIDE LIMITED TO 2 PER 351 DAYS
6742	PROCEDURE CODE D1206 IS LIMITED TO ONE PER 90 DAYS.
6743	PROCEDURE CODE D1206 IS LIMITED TO TWO PER YEAR.
6744	THIS SERVICE IS LIMITED TO 64 UNITS PER DAY OR IN COMBINATION WITH OTHER SELECT
6746	THIS SERVICE IS LIMITED TO ONE PER FOUR (4) YEARS.
6749	S5100 LIMITED TO 24 UNITS PER CALENDAR DAY
6750	S5100 LIMITED TO 120 UNITS PER CALENDAR WEEK
6753	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR.
7000	CLAIM FAILED A PRODUR ALERT

CODE	DESCRIPTION
7001	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT
7002	DENIED FOR PRODUR REASONS
7200	MISCELLANEOUS CLAIMCHECK ERROR
7201	PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR
7202	PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS
7203	PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS
7204	PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS
7205	PROCEDURE IS NOT INDICATED FOR A MALE
7206	PROCEDURE IS NOT INDICATED FOR A FEMALE
7207	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE
7208	PROCEDURE IS AN UNLISTED PROCEDURE
7209	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL
7210	PROCEDURE IS CLASSIFIED AS OBSOLETE
7211	PROCEDURE IS INVALID FOR PATIENT'S AGE
7212	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (AGE)
7213	PROCEDURE IS INVALID FOR PATIENT'S SEX
7214	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX)
7215	PROCEDURE CODE IS INCIDENTAL
7216	VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT
7217	PROCEDURE CODE HAS BEEN REBUNDLED
7218	PROCEDURE ADDED DUE TO REBUNDLING

CODE	DESCRIPTION
7219	PROCEDURE IS MUTUALLY EXCLUSIVE
7220	PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE
7221	PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE
7222	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON
7223	PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON
7233	DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL
7234	DENIED DUPLICATE - IS BILATERAL
7235	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME
7236	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY
7237	DENIED DUPLICATE (REBUNDLED)
7238	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	PROCEDURE IS A POSSIBLE DUPLICATE
7240	SMARTSUSPENSE SUSPEND
7241	SMARTSUSPENSE DENIAL
7242	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED
7243	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED
7244	MEDICAL VISIT DENIED
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS

CODE	DESCRIPTION
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7251	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE
7258	REVIEW MODIFIER 51
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS
7260	MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING
7261	INVALID PROCEDURE CODE
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE
7263	DOS REQUIRED FOR PROCEDURE
7264	DOS CANNOT BE A FUTURE DATE
7265	BIRTHDATE CANNOT BE A FUTURE DATE
7266	AGE CANNOT BE GREATER THAN 124 YEARS
7267	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES

CODE	DESCRIPTION
7269	MODIFIER NOT VALID FOR THIS PROCEDURE
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
7272	DIAGNOSIS 1 MUST BE A VALID CODE
7273	DIAGNOSIS 2 MUST BE A VALID CODE
7274	DIAGNOSIS 3 MUST BE A VALID CODE
7275	DIAGNOSIS 4 MUST BE A VALID CODE
7276	DIAGNOSIS MUST BE A VALID CODE
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
7278	INVALID DATE (DATE OF BIRTH)
7279	INVALID AMOUNT CHARGED
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7285	PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7286	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7287	DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR
7288	SMARTSUSPENSE FLAG
7289	SMARTSUSPENSE MONITOR

CODE	DESCRIPTION
7290	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE
7499	MEMBER LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER
7500	YOUR CLAIM IS BEING REVIEWED
7501	YOUR CLAIM IS BEING REVIEWED.
7502	MEMBER LOCKED IN TO A SPECIFIC PROVIDER
7503	MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALER
7504	MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT
7505	MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B.
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. CONTACT COLLEGE
7507	VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED
7508	Quantity dispensed on response claim same as original claim
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
8000	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR.
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER.
8002	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE.
8003	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR.
8004	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY.
8005	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN.
8006	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS

CODE	DESCRIPTION
	ERROR.
8007	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR.
8008	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR
8019	PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR.
8020	SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT.
8021	SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER.
8022	SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER.
8023	SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE
8024	SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE.
8025	SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT.
8026	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE.
8027	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE.
8028	SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE.
8030	PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR.
8031	PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE.
8032	PROVIDER REQUESTED OFFSET DUE MEDICARE.
8033	PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY.
8034	PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN.
8035	PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY.
8036	PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP

CODE	DESCRIPTION
8037	PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR.
8038	PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8039	YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM.
8040	PROVIDER INITIATED INTERNET ADJUSTMENT
8041	SAVE FOR FUTURE USE.
8042	SAVE FOR FUTURE USE.
8043	SAVE FOR FUTURE USE.
8044	SAVE FOR FUTURE USE.
8045	SAVE FOR FUTURE USE.
8046	SAVE FOR FUTURE USE.
8047	SAVE FOR FUTURE USE.
8048	SAVE FOR FUTURE USE.
8049	SAVE FOR FUTURE USE.
8050	SAVE FOR FUTURE USE.
8051	SAVE FOR FUTURE USE.
8052	SAVE FOR FUTURE USE.
8053	SAVE FOR FUTURE USE.
8054	SAVE FOR FUTURE USE.
8055	SAVE FOR FUTURE USE.
8056	SAVE FOR FUTURE USE.
8057	SAVE FOR FUTURE USE.

CODE	DESCRIPTION
8058	SAVE FOR FUTURE USE.
8059	PROVIDER SENT A FULL REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR.
8060	PROVIDER SENT REFUND DUE TO BILLING ERROR.
8061	PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR.
8062	PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT.
8063	PROVIDER SENT REFUND DUE TO EFT DEPOSIT ERROR.
8064	PROVIDER SENT REFUND DUE TO MEDICARE.
8065	PROVIDER SENT REFUND DUE TO OFMQ REVIEW.
8066	PROVIDER SENT REFUND DUE TO OTHER INSURANCE.
8067	PROVIDER SENT REFUND DUE TO SURS REVIEW.
8068	PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW.
8069	PROVIDER SENT REFUND DUE TO LEGAL SETTLEMENT.
8070	PROVIDER SENT REFUND DUE TO MEDICAID FRAUD.
8071	PROVIDER SENT REFUND PAYMENT DUE TO MEDICAID FRAUD.
8072	PROVIDER SENT REFUND DUE TO AUTO LIABILITY.
8073	PROVIDER SENT REFUND DUE TO WORKERS COMP.
8074	PROVIDER SENT REFUND FOR CLAIM NOT IN HISTORY.
8075	PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR.
8079	SAVE FOR FUTURE USE.
8080	SAVE FOR FUTURE USE.
8081	SAVE FOR FUTURE USE.

CODE	DESCRIPTION
8082	NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR.
8083	NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE.
8084	NON-CLAIM SPECIFIC REFUND DUE TO SURS.
8085	NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR.
8086	SAVE FOR FUTURE USE.
8087	SAVE FOR FUTURE USE.
8088	SAVE FOR FUTURE USE.
8101	SAVE FOR FUTURE USE.
8102	SAVE FOR FUTURE USE.
8103	SAVE FOR FUTURE USE.
8104	SAVE FOR FUTURE USE.
8105	SAVE FOR FUTURE USE.
8106	SAVE FOR FUTURE USE.
8107	SAVE FOR FUTURE USE.
8135	EDS INITIATED OFFSET DUE TO PROCESSING ERROR
8136	EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR
8141	SAVE FOR FUTURE USE.
8142	SAVE FOR FUTURE USE.
8143	SAVE FOR FUTURE USE.
8144	SAVE FOR FUTURE USE.
8145	SAVE FOR FUTURE USE.
8146	SAVE FOR FUTURE USE.

CODE	DESCRIPTION
8147	SAVE FOR FUTURE USE.
8148	SAVE FOR FUTURE USE.
8149	SAVE FOR FUTURE USE.
8166	EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR.
8167	EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR.
8179	REVERSAL/VOID TRANSACTIONS
8180	MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE.
8181	MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE
8182	MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE.
8183	MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE.
8184	MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE.
8186	MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE).
8187	OTHER REQUEST FOR MASS ADJUSTMENT
8188	VOID TRANSACTIONS - MASS ADJUSTMENT
8189	MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED
8190	MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED
8191	MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST
8199	SAVE FOR FUTURE USE.
8200	TPL PRIVATE HEALTH INSURANCE - CARRIER
8201	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	TPL PRIVATE HEALTH INSURANCE - MEMBER

CODE	DESCRIPTION
8203	AUTO LIABILITY - CARRIER
8204	AUTO LIABILITY - PROVIDER
8205	AUTO LIABILITY - MEMBER
8206	NON-AUTO LIABILITY - CARRIE
8207	NON-AUTO LIABILITY - PROVIDER
8208	NON-AUTO LIABILITY - MEMBER
8209	WORKER'S COMP - CARRIER
8210	WORKER'S COMP - PROVIDER
8211	WORKER'S COMP - MEMBER
8212	PROBATE'S ESTATE
8213	INCOME PENSION TRUST RECOVERIES
8214	VICTIM'S RESTITUTION
8215	ABSENT PARENTS
8216	TPL ERROR
8217	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	CHECK RELATED VOID PROCESSED
8221	SAVE FOR FUTURE USE.
8222	SAVE FOR FUTURE USE
8223	SAVE FOR FUTURE USE.
8224	SAVE FOR FUTURE USE.
8225	CAPITATION - DEATH OF MEMBER
8226	CAPITATION - MEMBER INCARCERATED

CODE	DESCRIPTION
8227	CAPITATION - EPSDT CLAIM
8228	CAPITATION - MEMBER ENROLLED IN ERROR
8229	CAPITATION - FAMILY PLANNING
8230	ICN VOIDED DUE TO WARRANT RETURN
8231	CAPITATION - DEMOGRAPHIC CHANGE
8232	CAPITATION - OTHER
8233	SAVE FOR FUTURE USE.
8234	SAVE FOR FUTURE USE.
8240	ADJUSTMENT GENERATED DUE TO SURS REVIEW
8241	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	POINT OF SALE
8246	POINT OF SALE REVERSAL
8299	ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS
8300	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED
8301	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXC
8302	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT
8303	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENT

CODE	DESCRIPTION
8304	PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE.
8305	PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE.
8306	CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMO
8307	PAYOUT EXCLUDED FROM CHECKWRITE.
8308	PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT
8309	PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT
8310	PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT
8311	PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM
8312	PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT
8313	PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT
8314	PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR
8315	PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR
8316	PAYOUT DUE TO MANAGED CARE - OTHER
8317	PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU
8318	PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR
8319	PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR
8320	PAYOUT DUE TO PATIENT LIABILITY ERROR
8321	PAYOUT DUE TO PATIENT SPENDDOWN ERROR
8322	PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES
8323	PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION
8325	PAYOUT DUE TO GAS SURCHARGE.

CODE	DESCRIPTION
8326	PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED.
8327	PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT.
8328	PAYOUT DUE TO DHS/DDSD AUDIT
8329	PAYOUT PROCESSED FROM STATE ONLY FUNDS
8330	PAYOUT DUE TO ELIGIBILITY NOT ON FILE.
8331	PAYOUT DUE TO CLAIM TOO OLD TO PROCESS
8332	PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON.
8336	RETROACTIVE INTEREST PAYMENT
8399	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED.
8400	ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED . THE AMOUNT WILL BE DEDUCTED FROM YO
8401	DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT
8402	DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WIL
8403	DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT
8404	DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED
8405	DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE
8406	DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE A
8407	RELEASE OF LIEN RECEIVED BY LIEN HOLDER
8408	DECREASE TO ORIGINAL LIEN AMOUNT.

CODE	DESCRIPTION
8409	INCREASE TO ORIGINAL LIEN AMOUNT
8410	SAVE FOR FUTURE USE
8411	SAVE FOR FUTURE USE
8412	SAVE FOR FUTURE USE
8413	SAVE FOR FUTURE USE
8414	SAVE FOR FUTURE USE
8415	SAVE FOR FUTURE USE .
8419	SAVE FOR FUTURE USE
8420	AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA
8421	AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTAB
8422	AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTA
8423	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT.
8424	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE.
8425	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE.
8426	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUS
8427	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE..
8428	AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN
8429	AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHE

CODE	DESCRIPTION
8430	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAI
8431	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS.
8432	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD.
8433	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW.
8434	AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. T
8435	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR.
8436	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR.
8437	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW.
8438	AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE
8439	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY.
8440	SAVE FOR FUTURE USE.
8441	SAVE FOR FUTURE USE.
8442	SAVE FOR FUTURE USE.
8443	SAVE FOR FUTURE USE.
8444	SAVE FOR FUTURE USE.
8445	SAVE FOR FUTURE USE.
8446	SAVE FOR FUTURE USE.

CODE	DESCRIPTION
8447	SAVE FOR FUTURE USE.
8448	SAVE FOR FUTURE USE.
8449	SAVE FOR FUTURE USE.
8450	DUE TO A TRANSFER OF ACCOUNT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE
8451	DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN A
8452	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED
8453	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR
8454	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE COR
8455	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORREC
8456	A CASH RECEIPT WAS APPLIED TO AND DECREASED THIS ACCOUNTS RECEIVABLE.
8457	AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE
8458	A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE.
8459	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW.
8460	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW
8461	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW.
8462	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW.

CODE	DESCRIPTION
8463	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW.
8464	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW.
8465	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED.
8466	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION
8467	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION.
8468	THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF.
8469	THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET
8500	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER.
8501	PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED.
8502	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY.
8510	CYCLE ACTIVITY
8511	DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
8512	DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED.
8513	INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER.
8514	RELEASE OF LIEN RECEIVED BY LIEN HOLDER.
8515	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION.
8600	ZERO CREDIT BALANCE
8601	PROV REFUND-HEALTH INSUR PAID
8602	PROV REFUND-RECIPIENT/REL PAID

CODE	DESCRIPTION
8603	PROV REFUND-CASUALTY INSU PAID
8604	PROV REFUND-PAID WRONG VENDER
8605	PROV REFUND-APPLY TO ACCT RECV
8606	PROV REFUND-PROCESSING ERROR
8607	PROV REFUND-BILLING ERROR
8608	PROV REFUND-FRAUD
8609	PROV REFUND-ABUSE
8610	PROV REFUND-DUPLICATE PAYMENT
8611	PROV REFUND-COST SETTLEMENT
8612	PROV REFUND-OTHER/UNKNOWN
8613	ACCT RECEIVABLE - FRAUD
8614	ACCT RECEIVABLE - ABUSE
8615	ACCT RECEIVABLE - TPL
8616	ACCT RECV - COST SETTLEMENT
8617	ACCT RECEIVABLE-KYMMIS REQUEST
8618	RECOUPMENT - WARRANT REFUND
8619	ACT RECEIVABLE-SURS OTHER
8620	ACCT RECEIVABLE - DUP PAYT
8621	RECOUPMENT - FRAUD
8622	CIVIL MONEY PENALTY
8623	RECOUPMENT-HEALTH INSUR TPL
8624	RECOUPMENT-CASUALTY INSUR TPL

CODE	DESCRIPTION
8625	RECOUPMENT-RECIPIENT PAID TPL
8626	RECOUPMENT - PROCESSING ERROR
8627	RECOUPMENT - BILLING ERROR
8628	RECOUPMENT - COST SETTLEMENT
8629	RECOUPMENT - DUPLICATE PAYMENT
8630	RECOUPMENT - PAID WRONG VENDOR
8631	RECOUPMENT - SURS
8632	PAYOUT-ADVANCE TO BE RECOUPED
8633	PAYOUT - ERROR ON REFUND
8634	PAYOUT - RTP
8635	PAYOUT - COST SETTLEMENT
8636	PAYOUT - OTHER
8637	PAYOUT - MEDICARE PAID TPL
8638	RECOUPMENT - MEDICARE PAID TPL
8639	RECOUPMENT - DEDCO
8640	PROVIDER REFUND-OTHER TPL RSN
8641	ACCT RECV - PATIENT ASSESSMENT
8642	ACCT RECV - ORTHODONTIC FEE
8643	ACCT RECEIVABLE - KENPAC
8644	PARTICIP REQUIREMENTS FAILURE
8645	ACCT RECEIVABLE - OTHER
8646	AR CDR HOSP AUDIT

CODE	DESCRIPTION
8647	ACT REC-DEMAND PAYMT UPDT 1099
8648	ACT REC-DEMAND PAYMT NO 1099
8649	PCG - PART A RECOVERIES
8650	RECOUPMENT - COLD CHECK
8651	PROG INTRE POST PAY REV CONT A
8652	PROG INTRE POST PAY REV CONT B
8653	CLAIM CREDIT BALANCE
8654	RECOUPMENT-OTHER ST BRANCH
8655	RECOUPMENT - OTHER
8656	RECOUPMENT - TPL CONTRACTOR
8657	ACCT RECV - ADVANCE PAYMENT
8658	RECOUPMENT - ADVANCE PAYMENT
8659	NON CLAIM RELATED OVERAGE
8660	PROVIDER INITIATED ADJUSTMENT
8661	PROVIDER INITIATED CLM CREDIT
8662	CLM CR-PAID MEDICAID VS XOVER
8663	CLM CR-PAID XOVER VS MEDICAID
8664	CLM CR-PAID INPATIENT VS OUTP
8665	CLM CR-PAID OUTPATIENT VS INP
8666	CLM CREDIT-PROV NUMBER CHANGED
8667	TPL CLM NOT FOUND ON HISTORY
8668	FIN CLM NOT FOUND ON HISTORY

CODE	DESCRIPTION
8669	FINANCIAL WITHHOLD PAYMENT
8670	KENPAC INCENTIVE PAYMENT
8671	ENC DATA UNACCEPTABLE
8672	AR OVERAGE LT 99
8673	NO MEDICAID/PARTNERSHIP ENROLL
8674	PROV DATA UNACCEPTABLE
8675	PCP DATA UNACCEPTABLE
8676	WITHHOLD OTHER
8677	RECIP INTENTIONAL PGM VIOLATE
8678	CAP ADJUSTMENT OTHER
8679	RECIPIENT NOT ELIGIBLE FOR DOS
8680	ADHOC ADJUSTMENT REQUEST
8681	ADJ DUE TO SYSTEM CORRECTIONS
8682	CONVERTED ADJUSTMENT
8683	MASS ADJ WARR REFUND
8684	DMS MASS ADJ REQUEST
8685	MASS ADJ SURS REQUEST
8686	THIRD PARTY PAID - TPL
8687	CLAIM ADJUSTMENT - TPL
8688	BEGINNING DUMMY RECOUPMENT BAL
8689	ENDING DUMMY RECOUPMENT BAL
8690	RETRO RATE MASS ADJ

CODE	DESCRIPTION
8691	BEGINNING CREDIT BALANCE
8692	ENDING CREDIT BALANCE
8693	BEGINNING DUMMY CREDIT BALANCE
8694	ENDING DUMMY CREDIT BALANCE
8695	BEGINNING RECOUPMENT BALANCE
8696	ENDING RECOUPMENT BALANCE
8697	BEGIN DUMMY REC BAL
8698	END DUMMY RECOUP BALANCE
8699	UNIT DOSE RETURN DRUG ADJ
8700	PCG 2 PART A RECOVERIES
8701	PCG 2 PART B RECOVERIES
8702	PCG 2 AR CDR HOSP
8703	CONVERTED CLAIM CREDIT BALANCE
8704	DRG RETRO REVIEW
8705	DECEASED RECIPIENT RECOUPMENTS
8706	IMPACT PLUS
8707	INTEREST RECEIVED
8708	PROG INTRE POST PAY REV CONT C
8709	ON DEMAND RECOUPMENT REFUND
8710	RECOUP PAYOUT
8711	RECOUPMENT REFUND
8712	STATE SHARE

CODE	DESCRIPTION
8713	KYMMIS MEDICARE PART A RECOUP
8714	REG. PSYCH. CROSSOVER REFUND
8998	CLAIM BEING REVIEWED
8999	ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95. THIS CLAIM HAS BEEN MANUALLY PRI
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE OKLAHOMA HE
9001	REIMBURSEMENT REDUCED BY THE MEMBER'S CO-PAYMENT AMOUNT.
9002	ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT.
9004	PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE ALLOWED AMOUNT.
9005	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS H
9006	THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE.
9007	A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT WI
9008	LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. PLEASE RESUBMIT WITH APPROPRIATE
9009	SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSPITAL CARE LIMITED TO ONCE PER
9010	SERVICE IS NON-COVERED UNDER THE OKLAHOMA HEALTH COVERAGE PROGRAM
9011	SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM.
9012	WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM.
9013	CLAIM UNDER REVIEW - FOR INTERNAL USE ONLY

CODE	DESCRIPTION
9016	THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DATES O
9017	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
9018	837 ADJUSTMENT ERROR -- MEMBER MEDICAID ID NOT PRESENT
9019	NO CROSSOVER PROVIDER NUMBER
9020	NO PROVIDER NUMBER
9021	UNABLE TO FIND ORIGINAL ICN FOR 837 ADJ REQUEST
9023	Provider not Found
9024	ORIGINAL CLAIM NOT FOUND
9025	837 ADJUSTMENT ERROR -- ORIGINAL CLAIM NOT FOUND
9026	837 ADJUSTMENT ERROR -- CLAIM HAS BEEN ADJUSTED
9027	837 ADJUSTMENT ERROR -- CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PROCESS
9030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT P
9031	GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIM
9036	ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVI
9040	REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTR
9075	CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY COMPLETED.
9080	NON COVERED CHARGES
9090	XOVER W/O MEDICARE SEGMENT FOR REVIEW

CODE	DESCRIPTION
9107	FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN THE AMOUNT PAID FOR COMPONENTS OF THE
9111	INTERNAL PROCESSING ERROR - CONTACT SE MANAGER
9122	NO PRICING METHOD ASSIGNED OR UNKNOWN
9175	CLAIM DENIED. MEMBER'S SIGNATURE AND DATE OF SIGNATURE IN THE MEMBER'S SECTION
9256	TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF \$850.00 PER MONTH, BUT IS N
9257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS \$280.00 PER 30 DAYS. MAXIMUM REIMBURSEME
9260	PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIE
9300	MASS ADJUSTMENT SUSPENDED FOR REVIEW
9301	MEMBER HAS MULTIPLE BENEFIT PLANS FOR DOS OF CLAIM
9302	INVALID BENEFIT PLAN ON CLAIM
9303	UNABLE TO ASSIGN PROVIDER CONTRACT
9400	THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION R
9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEM
9601	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR ME
9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBER'S SPENDOWN MET DATE FORTHE
9604	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YE
9605	HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD

CODE	DESCRIPTION
9634	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS H
9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PER
9660	THIS SERVICE IS NOT PAYABLE, MEMBER IS QMB ALSO AND SPENDDOWN HAS NOT BEEN MET
9661	POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM.
9664	THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS
9665	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS.
9666	THE ATTACHMENT TYPE IS NOT VALID.
9700	THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE
9701	THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY
9702	DOLLARS ADJUSTED TO PARAMETER LIMIT
9703	QTY ADJUSTED TO PARAMETER LIMIT
9704	COVERED DAYS REDUCED TO ALLOWABLE
9705	VISITS REDUCED TO AUTHORIZED
9706	PA CHARGE REDUCED TO AUTHORIZED
9707	PA UNITS REDUCED TO AUTHORIZED
9708	THER DAYS REDUCED TO AUTHORIZED
9709	MAX 14 CONSECUTIVE THER DAYS ALLOWED
9710	HOSP LEAVE DAYS REDUCED TO AUTHORIZED

CODE	DESCRIPTION
9800	CUTBACK DUE TO HMO PAYMENT/COVERAGE UNDER SOONERCARE PLUS PROGRAM
9900	REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE
9902	PROCEDURE CODE NOT FOUND ON GROUP
9903	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS
9904	SERVICE DENIED. REIMBURSEMENT LIMITED TO ONE SET OF LENSES EVERY TWO YEARS FOR
9905	SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STAT
9906	PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED
9907	TPL AMOUNT APPLIED
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED
9909	PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED
9910	PHARMACY DISPENSING FEE APPLIED
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED
9912	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED
9913	PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED
9914	PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED
9915	PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED
9917	PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED

CODE	DESCRIPTION
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED
9920	PRICING ADJUSTMENT - RBRVS PRICING APPLIED
9921	PRICING ADJUSTMENT - PA PRICING APPLIED
9922	SPENDDOWN DEDUCTIBLE/PATIENT LIABILITY APPLIED
9923	SPENDDOWN PATIENT LIABILITY APPLIED
9924	CLAIM HAS FICA AMOUNT
9925	CLAIM HAS RECOUPMENT AMOUNT
9926	CLAIM HAS CUTBACK AMOUNT
9927	SYSTEM FUND CODE REASSIGNMENT
9930	REVENUE CODE ZERO PAID WHEN BILLED WITH THIS PROCEDURE CODE.
9931	PRICING ADJUSTMENT - 100% MEDICARE COINS. & DEDUCT APPLIED
9932	PRICING ADJUSTMENT - DRG PRICING APPLIED
9933	PRICING ADJUSTMENT - APC PRICING APPLIED
9935	PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED
9936	PRICING ADJUSTMENT - MAX FLAT FEE 2 PRICING APPLIED
9937	PRICING ADJUSTMENT - UCC FLAT FEE PRICING APPLIED
9938	PRICING ADJUSTMENT - UCC FLAT FEE 2 PRICING APPLIED
9939	PRICING ADJUSTMENT - SCHOOL BASED GROUP PRICING APPLIED
9940	PRICING ADJUSTMENT - PROVIDER PERCENT BILLED APPLIED
9941	PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED
9942	PRICING ADJUSTMENT- MEMBER COUNTY PRICING APPLIED.

CODE	DESCRIPTION
9943	PRICING ADJUSTMENT-HOSPICE CROSSWALK PRICING APPLIED.
9944	PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED
9945	PRICING ADJUSTMENT - PROVIDER UNIT RATE PRICING APPLIED
9946	PRICING ADJUSTMENT- PROVIDER SPECIFIC PER DIEM RATES APPLIED
9947	PRICING ADJUSTMENT - BUNDLED RATE PRICING APPLIED
9948	OUTPATIENT ASC PRICING APPLIED
9949	INPATIENT AUTOMATED TRANSPLANT PRICING APPLIED
9950	PRICING ADJUSTMENT- PPDADD PRICING APPLIED
9951	PRICING ADJUSTMENT- PROVIDER MAX PER DIEM PRICING APPLIED
9952	PRICING ADJUSTMENT- REVENUE PCT PRICING APPLIED
9953	PRICING ADJUSTMENT- ZERO PAID PRICING APPLIED
9954	KY DEFAULT PERCENTAGE PRICING APPLIED
9955	PRICING ADJUSTMENT - LESSER ANESTHESIA PRICING APPLIED
9956	PRICING ADJUSTMENT - NDC PRICING APPLIED
9965	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES A QUADRANT.
9970	PRICING ADJUSTMENT - LT1918 PRICING APPLIED
9971	PRICING ADJUSTMENT - LTCPTA PRICING APPLIED
9972	PRICING ADJUSTMENT - LTNQMB PRICING APPLIED
9973	PRICING ADJUSTMENT - LTPD18 PRICING APPLIED
9975	PRICING ADJUSTMENT - LTCDME PRICING APPLIED
9991	REFUND AMOUNT LESS THAN ADJUSTED AMOUNT

CODE	DESCRIPTION
9992	REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT
9995	ADJUSTMENT DETAIL MANUALLY DENIED
9996	PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION.
9997	PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES C
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM PO
9999	PROCESSED PER MEDICAID POLICY