

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.	001	A1	Claim denied charges.	M52	Missing/incomplete/invalid "from" date(s) of service.
002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE.	002	A1	Claim denied charges.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).
003	PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE.	003	A1	Claim denied charges.	M59	Missing/incomplete/invalid "to" date(s) of service.
004	MEDICARE PAID DATE IS MISSING OR INVALID.	004	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
005	EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES (HOSP ADM, ER VIS, CONSULT, OV)/RECIPIENT/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1 OF THESE PROCEDURES.	342, 343, 358, 360, 363, 406	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
006	THE DISCHARGE DATE IS MISSING OR INVALID.	006	A1	Claim denied charges.	N50	Missing/incomplete/invalid discharge information.
007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.	007	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.
008	CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE WHICHEVER IS LATER	008	29	The time limit for filing has expired.	MA119	Provider level adjustment for late claim filing applies to this claim.
009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIM WITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION.	054	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N26	Missing/incomplete/invalid itemized bill.
010	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT.	355	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	N29	Missing documentation/orders/notes/summary/report/invoice.
				Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this days supply.		
011	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN	011	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this days supply.	M53	Missing/incomplete/invalid days or units of service.
012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.	012	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this days supply.	M63	We do not pay for more than one of these on the same day.
013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE.	013	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID.	014	A1	Claim denied charges.	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH.	017	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.	018	A1	Claim denied charges.	M49	Missing/incomplete/ invalid value code(s) or amount(s).

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019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.	019	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M20	Missing/incomplete/invalid HCPCS.
020	MEDICARE DOCUMENTATION NOT ATTACHED.	020, 256	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
021	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.	355	A1	Claim denied charges.	M29	Missing/incomplete/invalid operative report.
			A1	Claim denied charges.	MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.	022	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
023	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.	355	A1	Claim denied charges.	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID.	024	A1	Claim denied charges.	M79	Missing/incomplete/invalid charge.
025	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.	025	128	Newborn's services are covered in the mother's Allowance.	MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.	026	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N34	Incorrect claim form for this service.
027	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.	480, 490	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
					N34	Incorrect claim form for this service.
028	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.	355	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC PROCEDURE CODE AND CRITERIA SET FOR REVIEW.	180, 181, 182, 183, 232, 256, 355, 374, 654, 846, 858, 860, 861, 862, 883, 884, 885, 886	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
030	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.	030	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service.
031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.	031	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
033	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES	033	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.
034	DENIED BY MEDICARE.	034	96	Non-covered charge(s).		
035	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE	035	46	This (these) service(s) is (are) not covered.	N20	Service not payable with other service rendered on the same date.
			96	Non-covered charge(s).	MA66	Missing/incomplete/invalid principal procedure code or date.
036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.	036	A1	Claim denied charges.	N20	Service not payable with other service rendered on the same date.
037	MODEL WAIVER 1 RECIPIENT LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE.	682	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE	038	96	Non-covered charge(s).	M77	Missing/incomplete/invalid place of service.

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039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE.	630, 672	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.
040	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.	040, 050, 480	5	The procedure code/bill type is inconsistent with the place of service.	MA30	Missing/incomplete/invalid type of bill.
041	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, RECIPIENT.	331, 403	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
042	CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB.	042	45	Charges exceed your contracted/legislated fee arrangement.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
043	CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID.	043	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N27	Missing/incomplete/invalid treatment number.
					N29	Missing documentation/orders/notes/summary/report/invoice.
044	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID	044	96	Non-covered charge(s).	M50	Missing/incomplete/invalid revenue code(s).
045	TYPE OF BILL INVALID FOR PROVIDER TYPE.	355	A1	Claim denied charges.	MA30	Missing/incomplete/invalid type of bill.
046	CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE.	046	A1	Claim denied charges.	M51	Missing/incomplete/invalid procedure code(s) and/or rates.
047	PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE	047	42	Charges exceed our fee schedule or maximum allowable amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
					N13	Payment based on professional/technical component modifier(s).
048	CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MANUAL AND RESUBMIT.	048	100	Payment made to patient/insured/responsible party.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
			129	Payment denied - Prior processing information appears incorrect.		
049	CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED AMOUNT.	049	23	Payment adjusted because charges have been paid by another payer.		
			42	Charges exceed our fee schedule or maximum allowable amount.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT	050	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL.	051	A1	Claim denied charges.	M44	Missing/incomplete/invalid condition code.
052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS.	052	133	The disposition of this claim/service is pending further review.		
053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.	053	A1	Claim denied charges.		Missing/incomplete/invalid total charges.
054	CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM	054	A1	Claim denied charges.		
055	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED.	055	A1	Claim denied charges.	M54	Missing/incomplete/invalid total charges.
056	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY.	179	54	Multiple physicians/ assistants are not covered in this case.	N55	Procedures for billing with group/referring/performing providers were not followed.
057	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.	015	A1	Claim denied charges.	MA30	Missing/incomplete/invalid type of bill.
058	CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.	011	A1	Claim denied charges.	N63	Rebill services on separate claim lines.

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059	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID.	059	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/ invalid total charges.
060	CLAIM DENIED. LOCATION CODE INVALID.	060	A1	Claim denied charges.	N79	Service billed is not compatible with patient location information.
					M58	Missing/incomplete/ invalid claim information. Resubmit claim after corrections.
061	PAID IN FULL BY MEDICAID.	061	92	Claim Paid in full.	MA125	Per legislation governing this program, payment constitutes payment in full.
062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.	062	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N46	Missing/incomplete/ invalid admission hour.
063	CLAIM DENIED. AN 8-DIGIT LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FORM LOCATOR #11.	063	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N77	Missing/incomplete/ invalid designated provider number.
			16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.		
064	THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN.	064	A1	Claim denied charges.		
065	DESTINATION CODE IS MISSING/INVALID.	065	A1	Claim denied charges.	N157	Transportation to and from this destination is not covered.
066	PRO STICKER/INDICATOR MISSING OR INVALID	066	62	Payment denied/reduced for absence of, or exceeded, pre-certification /authorization.	M49	Missing/incomplete/ invalid value code(s) or amount(s).
					M58	Missing/incomplete/ invalid claim information. Resubmit claim after corrections.
067	FAMILY PLANNING INDICATOR INVALID.	067	A1	Claim denied charges.	M49	Missing/incomplete/ invalid value code(s) or amount(s).
					M58	Missing/incomplete/ invalid claim information. Resubmit claim after corrections.
068	AM/PM PICK-UP INDICATOR MISSING OR INVALID.	068	A1	Claim denied charges.	M49	Missing/incomplete/ invalid value code(s) or amount(s).
					M58	Missing/incomplete/ invalid claim information. Resubmit claim after corrections.
069	TIME OF CALL IN MISSING/INVALID.	069	A1	Claim denied charges.	M125	Missing/incomplete/ invalid information on the period of time for which the service/supply/ equipment will be needed.
070	TIME OF PICK UP IS MISSING OR INVALID.	070	A1	Claim denied charges.		
071	MORE THAN 10 ERRORS AT THE HEADER LEVEL	071	A1	Claim denied charges.		
072	PICK-UP LOCATION CODE MISSING OR INVALID.	072	A1	Claim denied charges.	N53	Missing/incomplete/invalid point of pick-up address.
073	REFERRED TO "OTHER" CODE INVALID.	073	A1	Claim denied charges.	M49	Missing/incomplete/ invalid value code(s) or amount(s).
					M58	Missing/incomplete/ invalid claim information. Resubmit claim after corrections.
074	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT.	074	B5	Payment adjusted because overage/ program guidelines were not met or were exceeded.	M2	Not paid separately when the patient is an inpatient
			97	Payment is included in the allowance for another service/procedure.		
076	OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID.	076	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
077	CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING	077	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
078	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.	078	A1	Claim denied charges.	M51	Missing/incomplete/ invalid procedure code(s) and/or rates.

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079	CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES).	079	A1	Claim denied charges.	M54	Missing/incomplete/ invalid total charges.
080	PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE.	080	A1	Claim denied charges.	N95	This provider type/ provider specialty may not bill this service.
081	CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID.	081	A1	Claim denied charges.	N76	Missing/incomplete/invalid number of riders.
082	CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID.	082	A1	Claim denied charges.		
083	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID	083	A1	Claim denied charges.	MA06	Missing/incomplete/ invalid beginning and/or ending date(s).
084	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.	084	A1	Claim denied charges.	MA06	Missing/incomplete/ invalid beginning and/or ending date(s).
085	CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER	085	A1	Claim denied charges.	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.
086	PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLLMENT AT (877) 838-5085 FOR NF OR ICF/MR.	086	A1	Claim denied charges.	N77	Missing/incomplete/ invalid designated provider number.
					M57	Missing/incomplete/ invalid provider identifier.
087	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.	087	110	Billing date predates service date.	M59	Missing/incomplete/ invalid "to" date(s) of service.
088	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.	088	A1	Claim denied charges.	MA52	Missing/incomplete/ invalid date.
089	DETAIL CHARGE MISSING OR INVALID.	089	A1	Claim denied charges.	M79	Missing/incomplete/invalid charge.
090	CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID.	090	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
091	CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR COMPLETION OF A PARTIAL EXAM FOR PROCESSING.	091	A1	Claim denied charges.		
092	THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT.	182	A1	Claim denied charges.	M30	Missing/incomplete/ invalid pathology report.
093	THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES.	182, 183	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
094	PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE	181	A1	Claim denied charges.	N3	Missing/incomplete/ invalid consent form.
					N28	Consent form requirements not fulfilled.
095	CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM	181, 183	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
096	RECIPIENT'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE.	183	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					MA52	Missing/incomplete/invalid date.
097	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.	181	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
098	RECIPIENT MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.	181	6	The procedure/revenue code is inconsistent with the patient's age.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
099	PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF RECIPIENT SIGNATURE BUT PRIOR TO THE STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID.	181	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID.	100	A1	Claim denied charges.	M52	Missing/incomplete/invalid "from" date(s) of service.
101	DETAIL TO DATE OF SERVICE MISSING OR INVALID.	101	A1	Claim denied charges.	M59	Missing/incomplete/invalid "to" date(s) of service.

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102	CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. VERIFIES THAT EACH DETAIL OF A CLAIM IS RECEIVED WITHIN 1 YEAR FROM THE DATE OF WHICH THE SERVICE WAS RENDERED.	102	29	The time limit for filing has expired.	MA119	Provider level adjustment for late claim filing applies to this claim.
103	MISSING OR ALTERED RECIPIENT SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE. CLAIM NOT PAYABLE BY MEDICAID.	181, 183	A1	Claim denied charges.	N29	Missing documentation/orders/notes/summary/report/invoice.
					N28	Consent form requirements not fulfilled.
106	INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES. (Hospice Recipient Eligibility Status - Recycle Edit)	106	97	Payment is included in the allowance for another service/procedure.	N19	Procedure code incidental to primary procedure.
107	INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT (Hospice Recipient)	107	97	Payment is included in the allowance for another service/procedure.	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
108	CONSENT FORM IS INCOMPLETE	181, 183	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
109	INCORRECT STERILIZATION CONSENT FORM USED.	181	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
110	CLAIM SUSPENDED FOR REVIEW.	001 - 003, 005 - 009, 011 - 013, 015 - 016, 018 - 019, 022, 026, 030, 035 - 036, 043, 048, 050 - 060, 062 - 063, 065 - 068, 070 - 074, 078 - 079, 082 - 084, 087 - 088, 094 - 097, 100 - 107, 113, 115, 117, 121, 123 - 124, 127, 129, 136 - 137, 141 - 142, 144, 146 - 150, 152 - 154, 156, 158, 162, 164 - 177, 179 - 183, 185, 186, 190, 193 - 196, 198, 200 - 201, 204 - 205, 210 - 211, 214 - 216, 220, 223, 232, 235, 240, 242 - 245, 255, 257, 273, 283, 303, 305, 307, 325, 327, 330, 332 - 333, 354 - 355, 368 - 372, 374 - 377, 393, 398, 412, 510 - 512, 574, 640, 673, 696, 700, 777, 828, 830 - 837, 889 - 893, 895 - 896, 898, 900 - 901, 904, 906 - 908, 912, 915 - 919, 923, 927 - 928, 931, 933, 950, 953 - 954, 956 - 959, 964 - 968, 972 - 978, 981 - 982, 984 - 989, 991 - 997.	133	The disposition of this claim/service is pending further review.	MA07	The claim information has also been forwarded to Medicaid for review.
111	ADJUSTMENT REQUEST IN PROCESS		133	The disposition of this claim/service is pending further review.	MA67	Correction to a prior claim.
112	CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILING LIMITATION. PLEASE CALL UNISYS PROVIDER SERVICES FOR ASSISTANCE.	008, 102	A1	Claim denied charges.	N225	Incomplete/invalid documentation/orders/ notes/ summary/ report/ invoice.
			16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	MA119	Provider level adjustment for late claim filing applies to this claim.
113	CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE. (Hospice - QMB Esc 245 only)	180, 245, 284, 355, 654, 670	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.

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114	REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID.	181	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
115	PAYMENT APPLIED TO RECEIVABLE. (Hospital)	115	88	Adjustment amount represents collection against receivable created in prior overpayment.		
116	DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL.	180	A1	Claim denied charges.	N29	Missing documentation/orders/notes/summary/report/invoice.
117	THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM	117	A1	Claim denied charges.		
118	OUR RECORDS INDICATE PAID IN FULL BY MEDICARE.	118	96	Non-covered charge(s).	M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.
119	NOT COVERED UNDER THE PROGRAM EXCEPT UNDER EPSDT.	119	96	Non-covered charge(s).	N59	Please refer to your provider manual for additional program and provider information.
120	LAB PROCESSING CHARGE INCLUDED IN FLAT FEE.	120	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
121	THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY RECIPIENT	121	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDICAID WITH A COPY OF THE MEDICARE EOMB.	122	A1	Claim denied charges.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
123	CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE RECIPIENT'S 1ST BIRTHDAY. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL.	123	6	The procedure/revenue code is inconsistent with the patient's age.	N30	Recipient ineligible for this service.
124	CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR RECIPIENTS AGE 22 THROUGH 64.	124 (pend only), 144	6	The procedure/revenue code is inconsistent with the patient's age.	N30	Recipient ineligible for this service.
125	THE TOOTH NUMBER IS MISSING OR INVALID.	125, 128	A1	Claim denied charges.	N37	Missing/incomplete/invalid tooth number/letter.
126	PROCEDURE CODE(S) IS INVALID FOR OTHER THAN ANTERIOR TOOTH NUMBERS.	126	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
127	CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID.	127	A1	Claim denied charges.	N75	Missing/incomplete/invalid tooth surface information.
128	THE TOOTH NUMBER IS MISSING OR INVALID.	128	A1	Claim denied charges.	N37	Missing/incomplete/invalid tooth number/letter.
130	THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	130, 872	119	Benefit maximum for this time period has been reached.		
131	CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY.	131, 870	119	Benefit maximum for this time period has been reached.		
132	SERVICE NOT AUTHORIZED.	132	38	Services not provided or authorized by designated (network/primary care) providers.	N54	Claim information is inconsistent with pre-certified/authorized services.
134	MAP-34 FORM INCOMPLETE.	255, 256, 282, 283	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
136	PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE.	136	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service.
137	CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHARGES.	137	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.		
138	CLAIM DENIED. LOCK-IN RECIPIENT.	640	38	Services not provided or authorized by designated (network/primary care) providers.	N30	Recipient ineligible for this service.
139	XH100 LIMITED TO 20 UNITS PER CALENDAR YEAR, PER RECIPIENT.	139	119	Benefit maximum for this time period has been reached.		

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
140	CLAIM PENDING REVIEW. RECIPIENT IS A POTENTIAL LOCK-IN RECIPIENT.	140	38	Services not provided or authorized by designated (network/primary care) providers.	N30	Patient ineligible for this service.
			133	The disposition of this claim/service is pending further review.		
141	PROCEDURE CODE MODIFIER MISSING/INVALID.	141	B18	Payment denied because this procedure code/ modifier was invalid on the date of service of claim submission.	M78	Missing/incomplete/invalid HCPCS modifier.
142	PREGNANCY INDICATOR FOR REIPIENT AGE OR SEX.	142	A1	Claim denied charges.		
143	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE	143	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	M50	Missing/incomplete/invalid revenue code(s).
144	SHOULD BE BILLED BY PROVIDER OF SERVICE.	144	A1	Claim denied charges.	N32	Provider performing service must submit claim.
145	THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY.	145, 374	A1	Claim denied charges.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
146	THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE.	146, 374	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
			8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
147	PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER.	147	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
					M78	Missing/incomplete/invalid HCPCS modifier.
148	THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE.	148	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N79	Service billed is not compatible with patient location information.
			5	The procedure code/bill type is inconsistent with the place of service.		
149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE RECIPIENT'S AGE.	149	6	The procedure/revenue code is inconsistent with the patient's age.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
150	THIS PROCEDURE IS INVALID FOR THE RECIPIENT'S SEX.	150	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.
151	CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE	151, 158	B18	Payment denied because this procedure code/ modifier was invalid on the date of service of claim submission.	MA66	Missing/incomplete/invalid principal procedure code or date.
152	PROCEDURE/NDC/ REVENUE CODE INVALID OR NOT ON FILE.	152	B18	Payment denied because this procedure code/ modifier was invalid on the date of service of claim submission.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	153, 181, 182	11	The diagnosis is inconsistent with the procedure.	MA66	Missing/incomplete/invalid principal procedure code or date.
154	PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER.	154	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	MA66	Missing/incomplete/invalid principal procedure code or date.
155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD.	155	A1	Claim denied charges.	N55	Procedure for billing with group / referring / performing providers were not followed.
156	THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER.	374	A1	Claim denied charges.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
157	PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY.	157, 374	B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
			8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
158	CLAIM DENIED DUE TO INJURY DIAGNOSIS.	158	11	The diagnosis is inconsistent with the procedure.	M64	Missing/incomplete/invalid other diagnosis.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
159	MORE THAN ONE VISIT PER DETAIL DATE OF SERVICE NOT ALLOWED. EACH VISIT MUST BE BILLED AS SEPARATE LINE ITEMS.	159	96	Non-covered charge(s).	N63	Rebill services on separate claim lines.
160	PROCEDURE INVALID FOR TOOTH NUMBER INDICATED.	160	A1	Claim denied charges.	N39	Procedure code is not compatible with tooth number/letter.
161	CLAIM DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE	161	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).
162	CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY.	162	96	Non-covered charge(s).		
			11	The diagnosis is inconsistent with the procedure.		
164	PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.	164	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.
165	SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE.	165	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
166	CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR RECIPIENT'S AGE.	166	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.
167	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR RECIPIENTS AGE.	167	6	The procedure/revenue code is inconsistent with the patient's age.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR RECIPIENTS SEX.	168	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.
169	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR RECIPIENTS SEX	169	7	The procedure/revenue code is inconsistent with the patient's gender.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
170	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.	170	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.
171	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE.	171	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
172	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	172	11	The diagnosis is inconsistent with the procedure.	MA66	Missing/incomplete/invalid principal procedure code or date.
173	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE	173	11	The diagnosis is inconsistent with the procedure.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
174	PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE	174	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.
175	PROVIDER ON REVIEW FOR SECONDARY SURGICAL PROCEDURE	175	52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.		
176	PRIMARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW	176	A1	Claim denied charges.	MA66	Missing/incomplete/invalid principal procedure code or date.
177	SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW	177	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
178	EXPECTED DATE OF DELIVERY MUST BE AT LEAST 30 DAYS FROM DATE OF CONSENT.	181	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
179	CLAIM DENIED-PLEASE RESUBMIT CLAIM WITH REPORT OF PROCEDURE PERFORMED.	179	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
180	DETAIL PROCEDURE INDICATE AS ON REVIEW.	180	96	Non-covered charge(s).	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
					MA07	The claim information has also been forwarded to Medicaid for review
181	RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED.	181	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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182	RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE.	180, 182, 183, 355	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M29	Missing/incomplete/invalid operative report.
183	RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED.	183	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
184	RESUBMIT WITH MAP-235 OR MAP-236 ATTACHED IF APPROPRIATE.	182	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
185	CONSENT FORM MUST BE SIGNED BY RECIPIENT 30 DAYS PRIOR TO STERILIZATION	181	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
186	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY RECIPIENT.	181	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
187	STAMPED SIGNATURES ARE UNACCEPTABLE.	187	A1	Claim denied charges.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
188	CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RECOMMENDATION, MEDICAL CLEARANCE STATEMENT, AND INVOICE.	180	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
189	CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATION PROCEDURE IN CASES OF EMERGENCY SURGERY OR PREMATURE DELIVERY.	181	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N3	Missing/incomplete/invalid consent form.
					N28	Consent form requirements not fulfilled.
190	THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	190	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Missing/incomplete/invalid principal diagnosis.
191	THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	191	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
192	THIS DIAGNOSIS IS NOT COVERED FOR THE RECIPIENT'S AGE.	192	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.
193	THE SECONDARY DIAGNOSIS IS INVALID FOR THE RECIPIENT'S AGE.	193	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.
					M64	Missing/incomplete/invalid other diagnosis.
194	PRIMARY DIAGNOSIS IS INVALID FOR RECIPIENT'S SEX.	194	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.
195	THE SECONDARY DIAGNOSIS IS INVALID FOR RECIPIENT SEX.	195	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.
					M64	Missing/incomplete/invalid other diagnosis.
196	HEADER DIAGNOSIS OR COMBINATION OF 2 ON REVIEW	196	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Missing/incomplete/invalid principal diagnosis.
198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH.	198	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
200	CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS.	200	52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	N35	Program integrity/utilization review decision.
201	THIS DIAGNOSIS IS NOT PAYABLE FOR THIS PROVIDER TYPE.	201	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.
202	REC ARE LIMITED TO 1 EPSDT SCREENING PER TIME SPAN ACCORDING TO THE PERIODICITY SCHEDULE.	654	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
203	CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER 12/12/94.	203	A1	Claim denied charges.	M78	Missing/incomplete/invalid HCPCS modifier.
204	INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.	204	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	MA63	Missing/incomplete/invalid principal diagnosis.
205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE	205	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.
206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.	206	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
207	DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE.	207	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition.
208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS	208	11	The diagnosis is inconsistent with the procedure.		
209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINNING WITH 0.	209	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.	210	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
211	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE.	211	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.	212	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M49	Missing/incomplete/invalid value code(s) or amount(s).
					M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.	213	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.	214	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
215	CLAIM/DETAIL DENIED. RECIPIENT'S AGE NOT WITHIN VALID RANGES FOR THIRD DIAGNOSIS.	215	9	The diagnosis is inconsistent with the patient's age	M76	Missing/incomplete/invalid diagnosis or condition.
					M64	Missing/incomplete/invalid other diagnosis.
216	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR RECIPIENT'S SEX.	216	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.
					M64	Missing/incomplete/invalid other diagnosis.
217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE RECIPIENT' AGE.	217	9	The diagnosis is inconsistent with the patient's age		
218	FOURTH DIAGNOSIS IS INVALID FOR RECIPIENT'S SEX.	218	10	The diagnosis is inconsistent with the patient's gender.	M76	Missing/incomplete/invalid diagnosis or condition.
					M64	Missing/incomplete/invalid other diagnosis.
219	FOURTH HEADER DIAGNOSIS ON REVIEW.	219	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
220	SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY.	220	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	M64	Missing/incomplete/invalid other diagnosis.
221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE (Provider Has Died)	221	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
222	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE (Provider Has Been Cancelled)	222	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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223	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE (Provider Has Been Suspended)	223	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
225	NO HISTORY MATCH FOUND, PLEASE RESUBMIT.	225	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
226	CANNOT BE PROCESSED ON THIS CLAIM FORM.	226	A1	Claim denied charges.	N34	Incorrect claim form for this service.
227	CLAIM OVERLAPS YOUR FISCAL YEAR END.	227	A1	Claim denied charges.		
228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE.	228	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
229	CLAIM/DETAIL DENIED. BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE.	229	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M57	Missing/incomplete/invalid provider identifier.
					M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
230	THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE.	230	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
231	CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER FILE.	231	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA29	Missing/incomplete/invalid provider name, city, state, or zip code.
232	CLAIM/DETAIL DENIED. ACTION REASON CODE INDICATES PROVIDER IS ON REVIEW.	232	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N35	Program integrity/utilization review decision.
233	UPIN MISSING OR INVALID.	233	52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	M33	Missing/incomplete/invalid UPIN for the ordering/referring /performing provider.
234	CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW.	234	52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.		
235	SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM.	146, 182, 355	96	Non-covered charge(s).		
236	PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER.	236	52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.
237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE.	237	52	The referring/prescribing /rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	M57	Missing/incomplete/invalid provider identifier.
					M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
					N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.
238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.	238	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE.	239	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M57	Missing/incomplete/invalid provider identifier.
240	MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE.	240	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY.	080, 086, 108, 109, 110, 111, 112, 206, 221, 222, 228, 229, 289, 301, 829, 241	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26.	242	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
243	PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS PROVIDER TYPE.	243	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
244	PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SERVICES.	244	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
245	THESE SERVICES MAY BE BILLED ONLY BY A RECIPIENT'S HOSPICE PROVIDER.	245	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N32	Provider performing service must submit claim.
246	80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAME DOS/RECIPIENT/PROVIDER AS 80020-BLOOD COLLECTION VENIPUNCTURE.	346	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for same/similar procedure within set time frame.
248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM.	248	54	Multiple physicians/ assistants are not covered in this case.		
249	PAYMENT REDUCED BECAUSE OUR RECORDS SHOW RECIPIENT WAS NOT IN FACILITY FOR ALL OF THE TOTAL BILLED DAYS.	249	A1	Claim denied charges.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
					N32	Provider performing service must submit claim.
250	THIS RECIPIENT IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY RECIPIENT MAID NUMBER.	250	31	Claim denied as patient cannot be identified as our insured.		
251	INCORRECT RECIPIENT IDENTIFICATION NUMBER.	251	31	Claim denied as patient cannot be identified as our insured.		
252	RECIPIENT NAME ON CLAIM DOES NOT MATCH RECIPIENT NAME ON THE MEDICAID ELIGIBILITY DATABASE FOR THE MAID NUMBER SUBMITTED ON YOUR CLAIM.	252	140	Patient/insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.
253	OUR RECORDS INDICATE THE RECIPIENT WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE.	253	13	The date of death precedes the date of service.		
254	THE RECIPIENT IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES.	254, 259, 265	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.
			27	Expenses incurred after coverage terminated.		
255	RECIPIENT HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES.	255	96	Non-covered charge(s).	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
256	OUR RECORDS INDICATE THAT THIS RECIPIENT MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL MEDICARE FIRST. IF MEDICARE DENIES THIS SERVICE, RESUBMIT WITH PROOF OF DENIAL.	256	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
257	OUR RECORDS INDICATE THAT THE RECIPIENT WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE RECIPIENT IS NOT ELIGIBLE FOR THE SERVICE(S).	257	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
			6	The procedure/revenue code is inconsistent with the patient's age.		
258	MEDICARE SUSPECT/DENTAL.	258	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
259	THE RECIPIENT HAS MEDICARE PART B. PLEASE BILL MEDICARE.	259	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
			109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS RECIPIENT. MEDICAID CLAIMS ARE NOT REIMBURSABLE FOR THIS RECIPIENT.	260	96	Non-covered charge(s).	N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
261	OUR RECORDS INDICATE THAT THE RECIPIENT WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE.	261	13	The date of death precedes the date of service.		
262	RECIPIENT IS NOT ELIGIBLE ON THE DATE OF SERVICE.	259, 262	A1	Claim denied charges.	N30	Recipient ineligible for this service.
			26	Expenses incurred prior to coverage.		
			27	Expenses incurred after coverage terminated.		
263	CLAIM DENIED. RECIPIENT NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE.	263	A1	Claim denied charges.	N30	Recipient ineligible for this service.
			26	Expenses incurred prior to coverage.		
			27	Expenses incurred after coverage terminated.		
264	RECIPIENT NAME IS MISSING.	264	31	Claim denied as patient cannot be identified as our insured.	MA36	Missing/incomplete/invalid patient name.
265	INCORRECT RECIPIENT IDENTIFICATION NUMBER.	265	31	Claim denied as patient cannot be identified as our insured.		
266	RECIPIENT NOT ELIGIBLE FOR WAIVER SERVICES.	266	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
267	WAIVER PAYMENT AMOUNT REDUCED DUE TO RECIPIENT CONTINUING INCOME	267	142	Claim adjusted by the monthly Medicaid patient liability amount.		
268	RECIPIENT MAID NUMBER ON CLAIM DOES NOT MATCH THE RECIPIENT MAID NUMBER ON ATTACHED ELIGIBILITY CARD.	248, 249, 259, 262, 263, 265	140	Patient/insured health identification number and name do not match.		
			96	Non-covered charge(s).	MA61	Missing/incomplete/invalid social security number or health insurance claim number.
269	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO RECIPIENTS ENROLLED IN A WAIVER OR HOSPICE PROGRAM.	269	B9	Services not covered because the patient is enrolled in a Hospice.	N30	Recipient ineligible for this service.
270	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER RECIPIENT.	270	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
271	CLAIM DENIED. RECIPIENT AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE CONTACT DMS AT 502-564-6885.	271	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N58	Missing/incomplete/invalid patient liability amount.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

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273	CLAIM/DETAIL DENIED. PROCEDURE CODE 01351 IS LIMITED TO CERTAIN TOOTH NUMBERS.	273	A1	Claim denied charges.	N39	Procedure code is not compatible with tooth number/letter
274	RECIPIENT TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE.	274	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
			62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
275	INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID.	113, 274	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		
			62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M62	Missing/incomplete/invalid treatment authorization code.
276	DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATION RECIPIENTS.	276	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
277	THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT. CONTACT UNISYS PROVIDER RELATIONS FOR ASSISTANCE.	277, 279, 280, 281, 377, 467	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N225	Incomplete/invalid documentation/orders/ notes/ summary/ report/ invoice.
					MA92	Missing/incomplete/invalid primary insurance information.
278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY RECIPIENT.	279, 280, 281, 282, 283, 467	100	Payment made to patient/insured/responsible party.	MA92	Missing/incomplete/invalid primary insurance information.
279	CLAIM/DETAIL INDICATES RECIPIENT HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTERED ON CLAIM.	279	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92	Missing/incomplete/invalid primary insurance information.
			A1	Claim denied charges.		
280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST.	280	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
281	RECIPIENT HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.	281, 465	A1	Claim denied charges.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
282	THE RECIPIENT HAS MEDICARE PART A. PLEASE BILL MEDICARE.	282	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

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283	OUR RECORDS INDICATE RECIPIENT HAS MEDICARE PART B, PLEASE BILL MEDICARE.	283	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
284	OUR RECORDS INDICATE THAT THIS RECIPIENT IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST.	284	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
285	REGIONAL ANESTHESIA PROCEDURE CODES MAY NOT BE BILLED USING TYPE OF SERVICE 07, MODIFIER AG, OR MORE THAN ONE UNIT OF SERVICE PER DATE OF SERVICE.	185	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE.	186, 635	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M63	We do not pay for more than one of these on the same day.
287	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHNICAL COMPONENT REVENUE CODE.	187	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
288	PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL REVENUE CODE. CHARGES MOVED TO NON-COVERED.	187	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
289	RENDERING PROVIDER NUMBER MISSING OR INVALID .	289	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M57	Missing/incomplete/invalid provider identifier.
290	PENDING CONFIRMATION OF RECIPIENT ELIGIBILITY.	248, 249, 250, 251, 252, 253, 254, 259, 290, 291, 310, 399, 494	133	The disposition of this claim/service is pending further review.		
291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT.	291, 462, 467	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		
292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW.	292	133	The disposition of this claim/service is pending further review.		
293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW.	910	133	The disposition of this claim/service is pending further review.		
294	KENPAC RECIPIENT. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMARY PHYSICIAN/CLINIC NUMBER FOR THE DATE(S) OF SERVICE.	290	38	Services not provided or authorized by designated (network/primary care) providers.	M68	Missing/incomplete/invalid attending or referring physician identification.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

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					M57	Missing/incomplete/invalid provider identifier.
295	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE ENTERED IN FIELD 19.	291	38	Services not provided or authorized by designated (network/primary care) providers.	M68	Missing/incomplete/invalid attending or referring physician identification.
					M57	Missing/incomplete/invalid provider identifier.
296	CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER.	296	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	MA66	Missing/incomplete/invalid principal procedure code or date.
297	RECIPIENT IS NOT ELIGIBLE FOR HOSPICE.	297	28	Coverage not in effect at the time the service was provided.	N30	Recipient ineligible for this service.
			A1	Claim denied charges.		
298	RECIPIENT IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE.	298	28	Coverage not in effect at the time the service was provided.	N30	Recipient ineligible for this service.
			A1	Claim denied charges.		
299	HOSPICE RECIPIENT. OUR FILES SHOW RECIPIENT IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE.	299	B9	Services not covered because the patient is enrolled in a Hospice.	N30	Recipient ineligible for this service.
300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS		119	Benefit maximum for this time period has been reached.		
301	RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP.	301	A1	Claim denied charges.	N55	Procedures for billing with group/referring/performing providers were not followed.
303	THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE.	303	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.
304	OFFICE EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVAL	347, 348	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
305	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIONAL CODE (1ST DIGIT OF MODIFIER).	305	B18	Payment denied because this procedure code/ modifier was invalid on the date of service of claim submission.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
306	A HOSPICE RECIPIENT - RECYCLE FOR EDIT 298.	106, 306	B9	Services not covered because the patient is enrolled in a Hospice.	N30	Recipient ineligible for this service.
307	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH OTHER DESIGNATED PROCEDURES.	307	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
308	DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDICAL ASSISTANCE WAS PROVIDED.	180	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M29	Missing/incomplete/invalid operative report.
310	NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE	310	96	Non-covered charge(s).	MA41	Missing/incomplete/invalid admission type.
311	CORRECTED PAYMENT PER ADJUSTMENT REQUEST.		125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim.
316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTED. PLEASE CHECK RECORDS AND VERIFY TOOTH NUMBER.	316, 400	18	Duplicate claim/service.	N39	Procedure code is not compatible with tooth number/letter.
319	INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED.	319	133	The disposition of this claim/service is pending further review.	M57	Missing/incomplete/invalid provider identifier.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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321	EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES.	321	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.
322	EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROCEDURES.	322	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.
325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR RECIPIENT'S AGE.	325	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.
326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.	326	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
327	PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION.	327, 332, 355, 681, 104	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
328	PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION.	328	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION	329	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED.	330	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE.	331, 371	97	Payment is included in the allowance for another service/procedure.	M144	Pre-/post-operative care payment is included in the allowance for surgery / procedure.
					M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
333	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION.	333	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
334	SUPPLY NOT COVERED ON RENTAL ITEM.	334, 404	96	Non-covered charge(s).		
			D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.		
335	LACKS REPORT TO JUSTIFY HIGHER FEE.	335	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
			57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
337	CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/RECIPIENT/ PROVIDER.	336, 337, 338, 339	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FITTING OF A HEARING AID.	340	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
341	AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A HOSPITAL ADMISSION.	341	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
342	AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A CONSULTATION.	342	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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343	CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE	343	A2	Contractual adjustment.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.
344	AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM VISIT.	344	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
345	80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/ RECIPIENT/PROVIDER AS 80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF.	345	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
347	DENTURE RELATED EMERGENCY SERVICES 09110 AND UPPER OR LOWER DENTURE RELINE 05750 NOT PAYABLE ON SDOS	347	95	Benefits adjusted. Plan procedures not followed.	M63	We do not pay for more than one of these on the same day.
			97	Payment is included in the allowance for another service/procedure.		
348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE.	348	78	Non-Covered days/Room charge adjustment.		
349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS.	349, 350	97	Payment is included in the allowance for another service/procedure.	M63	We do not pay for more than one of these on the same day.
350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE OF SERVICE AS EMERGENCY SERVICES (09110) OR SEALANTS (01351).	351, 352	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
351	INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED.	351	78	Non-Covered days/Room charge adjustment.	MA33	Missing/incomplete/invalid noncovered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
352	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED.	355	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
353	INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWABLE PER ALLERGY TESTING OF SERVICE.	353, 405	97	Payment is included in the allowance for another service/procedure.	M71	Total payment reduced due to overlap of tests billed.
354	CLAIM DENIED. LITER FLOW PER MINUTE AND NUMBER OF HOURS MUST BE PRESENT TO PROCESS CLAIM.	355	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.		
355	FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT	355, 621	B5	Payment adjusted because coverage/ program guidelines were not met or were exceeded.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
356	CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS.	355	A1	Claim denied charges.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication /medical or dental advisor.
					M85	Subjected to review of physician evaluation and management services.
357	INVOICE MUST HAVE ITEM BILLED NOTED.	357	A1	Claim denied charges.	N29	Missing documentation/orders/notes/summary/report/invoice.
359	REFER TO THE ADJUSTMENT REASON CODE.	359	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim.
360	FEE ADJUSTED PER CLAIM CREDIT.	360	88	Adjustment amount represents collection against receivable created in prior overpayment.	MA67	Correction to a prior claim.

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361	GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SPECIAL OPHTHALMOLOGICAL SERVICES.	361, 362	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
362	PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM.	362	142	Claim adjusted by the monthly Medicaid patient liability amount.		
363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION	364, 365	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
364	PAYMENT REDUCED BY OTHER INSURANCE		23	Payment adjusted because charges have been paid by another payer.		
365	FEE ADJUSTED TO MAXIMUM ALLOWABLE.		42	Charges exceed our fee schedule or maximum allowable amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED \$50.00 PER UNIT OF SERVICE.	366	42	Charges exceed our fee schedule or maximum allowable amount.	M139	Denied services exceed the coverage limit for the demonstration.
367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE.	367	119	Benefit maximum for this time period has been reached.	MA125	Per legislation governing this program, payment constitutes payment in full.
368	PROVIDER IS NOT ELIGIBLE TO BILL FOR HOME HEALTH SUPPLIES AND/OR VISITS.	368	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE.	309, 407	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
370	PAYMENT MODE NOT FOUND FOR BILLING PROVIDER	370	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE	371	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE.	373, 408	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY.	539	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINANCIAL ITEMS.	374	A1	Claim denied charges.		
376	CLAIM DENIED. MAC FIELD INVALID.	376	A1	Claim denied charges.		
377	RECIPIENT INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM.	377	42	Charges exceed our fee schedule or maximum allowable amount.		
379	PAID BY MEDICAID		42	Charges exceed our fee schedule or maximum allowable amount.	MA125	Per legislation governing this program, payment constitutes payment in full.
380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT.		3	Co-payment Amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT	381, 382	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

<b>KY EOB</b>	<b>MEDICAID DESCRIPTION</b>	<b>MMIS EXCEPTION CODE(S)</b>	<b>HIPAA ADJ RSN CODES</b>	<b>HIPAA ADJ RSN CODE DESCRIPTION</b>	<b>HIPAA REMARK</b>	<b>HIPAA REMARK CODE DESCRIPTION</b>
382	DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN \$100.00.	355	A1	Claim denied charges.	M54	Missing/incomplete/invalid total charges.
383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY.	383, 384	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.	384	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS A D & C. PROCEDURE.	385, 386	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.	355	42	Charges exceed our fee schedule or maximum allowable amount.	N29	Missing documentation/orders/notes/summary/report/invoice.
387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE.	387, 388	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO NON-COVERED.	188	96	Non-covered charge(s).	M50	Missing/incomplete/invalid revenue code(s).
			97	Payment is included in the allowance for another service/procedure.		
389	PAID CLAIM BASED UPON MEDICAL REVIEW.	670	B5	Payment adjusted because coverage/ program guidelines were not met or were exceeded.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication /medical or dental advisor.
391	DETAIL DENIED. PROCEDURE CODE X0091 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0061, X0088, OR X0089.	391	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
392	DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091.	392	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE.	393	12	The diagnosis is inconsistent with the provider type.	MA63	Missing/incomplete/invalid principal diagnosis.
394	HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE SERVICES.	394	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
395	THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REIMBURSEMENT FOR THIS SERVICE. THE CLAIM IS PAID IN FULL. RECIPIENT SHALL NOT BE BILLED BALANCE.		23	Payment adjusted because charges have been paid by another payer.	N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES.	396	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM.	097	5	The procedure code/bill type is inconsistent with the place of service.		

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	398	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS RECIPIENT.	399	96	Non-covered charge(s).	N30	Recipient is ineligible for this service
403	PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE.	403	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
404	NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332.	104, 404	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
			133	The disposition of this claim/service is pending further review.		
409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.	009	52	The referring/prescribing /rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	N34	Incorrect claim form for this service.
410	FORMAT INVALID FOR ELECTRONIC CLAIMS. PLEASE CONTACT ECS HELP DESK AT 1-800-205-4696.	009, 410	A1	Claim denied charges.	M60	Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.
411	DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERVICE ON SEPARATE INVOICES - ONE INVOICE FOR EACH MONTH.	411	A1	Claim denied charges.	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.	412	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
413	RECIPIENT NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.	413	96	Non-covered charge(s).	N52	Patient not enrolled in the billing providers managed care plan on the date of service.
414	RECIPIENT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE.	414	24	Payment for charges adjusted. Charges are covered under a capitation agreement/ managed care plan	N30	Recipient ineligible for this service.
415	FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE.	415	24	Payment for charges adjusted. Charges are covered under a capitation agreement/ managed care plan		
416	CAPITATION RATE NOT WITHIN DATES OF SERVICE.	416	24	Payment for charges adjusted. Charges are covered under a capitation agreement/ managed care plan	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
417	CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR.	417	A1	Claim denied charges.		
418	CLAIM DENIED. INVALID ENCOUNTER TYPE.	418	A1	Claim denied charges.		
419	CLAIM DENIED. INVALID ENC RECEIPT DATE.	419	A1	Claim denied charges.		
420	CLAIM DENIED. INVALID ENC PAYMENT AMOUNT.	420	A1	Claim denied charges.		
421	CLAIM DENIED. INVALID ENC PAYMENT DATE.	421	A1	Claim denied charges.		
422	CLAIM DENIED. INVALID ENC ADJUSTMENT TCN.	422	A1	Claim denied charges.		
423	CLAIM DENIED. INVALID RECIP NOT ELIG FOR PHYSICAL.	423	A1	Claim denied charges.	N30	Recipient ineligible for this service
424	CLAIM DENIED. INVALID RECIP NOT ELIG FOR BEHAVIORAL.	424	A1	Claim denied charges.	N30	Recipient ineligible for this service
425	DETAIL DENIED. ENCOUNTER-ONLY PROCEDURE CODE. THIS PROCEDURE CODE IS NOT PAYABLE FOR FEE-FOR-SERVICE CLAIMS.	425	A1	Claim denied charges.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
427	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE.	490	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.
					M63	We do not pay for more than one of these on the same day.
428	FFS NOT ALLOWED, RECIP ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE.	428	A1	Claim denied charges.	N30	Recipient ineligible for this service
429	CLAIM DENIED. PARTNERSHIP NUM MISMATCH	429	A1	Claim denied charges.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
430	CLAIM DENIED. ENCOUNTER, INV. TCN TO CREDIT	430	A1	Claim denied charges.		
431	RESERVED FOR MANAGED CARE.	431	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
432	CLAIM DENIED. SEQ# MISMATCH ACROSS CLAIM.	432	A1	Claim denied charges.		
433	CLAIM DENIED. VOID/RESUB INVALID FOR XOVER.	433	A1	Claim denied charges.		
434	RESERVED FOR MANAGED CARE.	434	A1	Claim denied charges.		
435	RESERVED FOR MANAGED CARE.	435				
436	RESERVED FOR MANAGED CARE.	436				
437	CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAYS PRIOR TO AN INPATIENT HOSPITAL ADMISSION (AND VICE VERSA).	437	97	Payment is included in the allowance for another service/procedure.		
440	REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY)	440	119	Benefit maximum for this time period has been reached.		
441	PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER RECIPIENT	441	97	Payment is included in the allowance for another service/procedure.		
442	THIS PROCEDURE CODE IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODES 99244 AND 99245	442	97	Payment is included in the allowance for another service/procedure.		
443	PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS CERTAIN OTHER TITLE V PROCEDURE CODES	443	97	Payment is included in the allowance for another service/procedure.		
444	PLEASE CORRECT INVALID OR MISSING NDC NUMBER.	444	A1	Claim denied charges.	M119	National Drug code (NDC) needed.
445	PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PER RECIPIENT, PER PROVIDER	445	119	Benefit maximum for this time period has been reached.		
446	PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER RECIPIENT, PER PROVIDER	446	119	Benefit maximum for this time period has been reached.		
447	X0079 LIMITED TO 8 UNITS PER DAY	447	119	Benefit maximum for this time period has been reached.		
448	RECIPIENT NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250.	248	133	The disposition of this claim/service is pending further review.	N30	Recipient ineligible for this service.
449	THE RECIPIENT ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT.	249	31	Claim denied as patient cannot be identified as our insured.	MA61	Missing/incomplete/invalid social security number or health insurance claim number
450	CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER RECIPIENT, PER PROVIDER DURING THE RECIPIENT'S ASSESSMENT PERIOD ON THE PRIOR AUTHORIZATION FILE FOR THE CASE MANAGEMENT.	450	119	Benefit maximum for this time period has been reached.	N55	Procedures for billing with group/referring/performing providers were not followed.
					M139	Denied services exceed the coverage limit for the demonstration.
451	CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR AUTHORIZATION FILE. CONTACT PRO.	451	62	Payment denied/reduced for absence of, or exceeded, pre-certification /authorization.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication /medical or dental advisor.
					N54	Claim information is inconsistent with pre-certified/authorized services.
452	X0080 LIMITED TO 12 UNITS PER WEEK	452	119	Benefit maximum for this time period has been reached.		
453	X0061, X0088, X0089 AND X0103 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY	453	119	Benefit maximum for this time period has been reached.		
454	X0079 LIMITED TO 32 UNITS PER DAY.	454	119	Benefit maximum for this time period has been reached.		
455	THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.	455	119	Benefit maximum for this time period has been reached.		
456	THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	456	119	Benefit maximum for this time period has been reached.		
457	X0100 AND X0101 LIMITED TO ONE UNIT.	457	119	Benefit maximum for this time period has been reached.		
458	X0063 LIMITED TO \$150.00 PER DAY.	458	119	Benefit maximum for this time period has been reached.		
459	CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR.	459	119	Benefit maximum for this time period has been reached.		

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
460	THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.	460	119	Benefit maximum for this time period has been reached.		
461	XL307 LIMITED TO 80 UNITS PER WEEK.	461	119	Benefit maximum for this time period has been reached.		
462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX.	462	119	Benefit maximum for this time period has been reached.		
463	PAY TPL CLAIM.	463	119	Benefit maximum for this time period has been reached.		
464	PAY AND BILL TPL CLAIM.	464	119	Benefit maximum for this time period has been reached.		
465	RECIPIENT HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER AND SUBMIT ON PAPER.	465	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME RECIPIENT.	466	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
467	RECIPIENT HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.	467	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
					MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
					MA83	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
469	X0096 LIMITED TO 200 PER WEEK.	469	119	Benefit maximum for this time period has been reached.		
472	RECIPIENTS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRESCRIPTION/REFILL PER DATE OF SERVICE.	471	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
473	MEDICAID REIMBURSEMENT FOR THEI DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO	473	119	Benefit maximum for this time period has been reached.	MA125	Per legislation governing this program, payment constitutes payment in full.
476	RECIPIENT IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE.	476	18	Duplicate claim/service.	M2	Not paid separately when the patient is an inpatient.
477	RECIPIENT IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.	477, 495	18	Duplicate claim/service.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION OF THESE DATES OF SERVICE.	477	18	Duplicate claim/service.	M43	Payment for this service previously issued to you or another provider by another carrier / intermediary.
					N47	Claim conflicts with another inpatient stay.
479	CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER.	479	18	Duplicate claim/service.	M86	Service denied because payment already made for similar procedure within set time frame.
					M63	We do not pay for more than one of these on the same day.
					N20	Service not payable with other service rendered on the same date.
					N47	Claim conflicts with another inpatient stay.
481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	481	18	Duplicate claim/service.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	470, 472, 473, 474, 475, 480, 481, 483, 484, 485, 486, 488, 490	18	Duplicate claim/service.		
483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST.	487	18	Duplicate claim/service.		
484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER RECIPIENT.	487	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
					M63	We do not pay for more than one of these on the same day.
486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM.	093	96	Non-covered charge(s).	N38	Missing/incomplete/invalid place of service.
487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS.	094	11	The diagnosis is inconsistent with the procedure.		
489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.	489	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for similar procedure within set time frame.
					M63	We do not pay for more than one of these on the same day.
					N20	Service not payable with other service rendered on the same date.
490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.	590	60	Charges for outpatient services with this proximity to inpatient services are not covered.	N47	Claim conflicts with another inpatient stay.
491	CLAIM DENIED. RECIPIENT IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE.	491	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
					N47	Claim conflicts with another inpatient stay.
492	DCBS RECIPIENTS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT PLUS/CHMC SERVICES ON THE SAME DATE OF SERVICE.	492	97	Payment is included in the allowance for another service/procedure.		
493	DCBS RECIPIENTS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH SERVICES FROM TWO DIFFERENT SUB-PROVIDERS ON THE SAME DATE OF SERVICE.	493	97	Payment is included in the allowance for another service/procedure.		
494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE RECIPIENT'S 18TH BIRTHDAY.	494	6	The procedure/revenue code is inconsistent with the patient's age.		
496	ONLY ONE (1) ANESTHESIA/IV SEDATION ALLOWED PER DATE OF SERVICE PER RECIPIENT.	496	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON UNISYS ADJUSTMENT REQUEST FORM.	497	138	Claim/service denied. Appeal procedures not followed or time limits not met.	N34	Incorrect claim form for this service.
498	CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER RECIPIENT, PER DATE OF SERVICE.	498	35	Lifetime benefit maximum has been reached.	M63	We do not pay for more than one of these on the same day.
499	CLAIM PENDING REVIEW OF HISTORY.	The following exception codes apply to this EOB: 130-131, 139, 302, 304, 306, 308-309, 311-318, 321-324, 326, 331, 334-335, 337-339, 341-343, 347-352, 358, 360-365, 373, 381-388, 391-392, 394, 396, 400-404, 406-408, 441-442, 445-446, 466, 468, 471, 474, 477-484, 486-493, 495-496, 498, 501, 533-534, 537, 539-540, 542, 548-553, 556, 560, 569-570, 579-592, 606, 641, 643, 651-662, 667-668, 670, 672, 674-677, 680-683, 685-686, 688-693, 695, 697-698, 701-710, 712-714, 722, 724, 729-730, 732-735, 737-740, 742-744, 747, 749, 791, 798-819, 820, 822-823, 825-827, 846, 852-860, 862-863, 879-880, 883-885, 887	133	The disposition of this claim/service is pending further review.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
500	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS.	500, 524	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER RECIPIENT.	501	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
502	ONE FAMILY PLANNING SERVICE PER DOS.	302	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
503	ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER RECIPIENT PER NINE MONTHS PER CLINIC.	503, 523	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
504	FAMILY PLANNING RECIPIENTS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD.	304	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
505	RECIPIENT IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE.	478, 505	18	Duplicate claim/service.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
506	CBC AND COMPONENTS NOT ALLOWED SAME DOS.	306	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
507	PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS.	507	97	Payment is included in the allowance for another service/procedure.	M71	Total payment reduced due to overlap of tests billed.
508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS.	308	97	Payment is included in the allowance for another service/procedure.	M71	Total payment reduced due to overlap of tests billed.
509	RECIPIENTS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDER FOR DOS PRIOR TO SEPT. 1, 1985.	642	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
510	RECIPIENTS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVICE.	510	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE.	311, 401	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.	312	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
513	CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION.	313	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
514	CAST APPLICATION/ REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY.	314, 341	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
515	CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.	315, 335	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED.	316	18	Duplicate claim/service.		
517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER RECIPIENT PER PROVIDER.	317	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/RECIPIENT /PROVIDER. USE PROCEDURE 07120 FOR EACH ADDITIONAL TOOTH EXTRACTED	318	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INCLUDED IN DELIVERY FEE.	519	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
520	MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS.	520, 523	91	Dispensing fee adjustment.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount
521	COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIVE CLIENT EVALUATION.	521	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
522	COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME.	522	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
523	RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME DOS.	323	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
524	IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAME DOS.	324	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
525	IN-PATIENT RECIPIENTS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMISSION.	628, 647	97	Payment is included in the allowance for another service/procedure.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
					M139	Denied services exceed the coverage limit for the demonstration.
526	IN-PATIENT RECIPIENTS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR 1 CONSULTATION PER DATE OF SERVICE PER PROVIDER.	526	97	Payment is included in the allowance for another service/procedure.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED.	400	18	Duplicate claim/service.	M139	Denied services exceed the coverage limit for the demonstration.
528	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN PROCEDURE OR A FRACTURED INCISAL BUILD-UP.	402	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
529	CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE BEEN PAID FOR THE SAME TOOTH SAME DOS.	326	97	Payment is included in the allowance for another service/procedure.		
530	CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE.	481, 520, 521, 522	91	Dispensing fee adjustment.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount
531	PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.	531	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
532	RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM.	532	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
533	CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATION.	533	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
534	CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER PROCEDURE CODES.	534	97	Payment is included in the allowance for another service/procedure.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
535	PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FORM, USING BABY'S OWN NAME AND NUMBER.	535	A1	Claim denied charges.	N61	Rebill services on separate claims.
536	THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIGINAL EOMB INDICATING THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS.	536	18	Duplicate claim/service.	N4	Missing/incomplete/invalid prior insurance carrier EOB.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

<b>KY EOB</b>	<b>MEDICAID DESCRIPTION</b>	<b>MMIS EXCEPTION CODE(S)</b>	<b>HIPAA ADJ RSN CODES</b>	<b>HIPAA ADJ RSN CODE DESCRIPTION</b>	<b>HIPAA REMARK</b>	<b>HIPAA REMARK CODE DESCRIPTION</b>
537	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARIFICATION.	537	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
539	CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVICE PRIOR AUTHORIZED.	539	62	Payment denied/reduced for absence of, or exceeded, pre-certification /authorization.	M139	Denied services exceed the coverage limit for the demonstration.
540	HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AUTHORIZED THROUGH EPSDT SPECIAL SERVICES.	540	119	Benefit maximum for this time period has been reached.		
541	CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMIT FOR ADJUSTMENT WITH PAID RA OF CAST APPLICATION OR REMOVAL AND CORRECTED CLAIM WITH SURGERY CODE.	341, 541	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER RECIPIENT, PER 90 DAYS.	542	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
543	MULTIPLE SURGERIES FOR SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. YOUR CLAIM IS DENIED AND INSTRUCTIONS FOR SUBMITTING AN ADJUSTMENT ARE BEING FORWARDED TO YOU.	501, 543	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M79	Missing/incomplete/invalid charge.
545	MULTIPLE MEDICAL /SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. FILE AN ADJUSTMENT TO ADD ADDITIONAL PROCEDURES TO RELATED PAID CLAIM.	501	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M79	Missing/incomplete/invalid charge.
546	CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) MONTHS OLD.	500	29	The time limit for filing has expired.	MA06	Missing/incomplete/invalid beginning and/or ending date(s).
548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185.	548	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M50	Missing/incomplete/invalid revenue code(s).
547	CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED.	N/A	142	Claim adjusted by the monthly Medicaid patient liability amount.		
549	CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARIFICATION.	549	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
550	PROCEDURE CODE 00140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME RECIPIENT, SAME PROVIDER, AND SAME DATE OF SERVICE.	550	A1	Claim denied charges.	M15	Separately billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY	551	97	Payment is included in the allowance for another service/procedure.		
552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY.	552	119	Benefit maximum for this time period has been reached.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
553	CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATED.	553	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT.	554	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	N4	Missing/incomplete/invalid prior insurance carrier EOB.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
555	PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL.	555	129	Payment denied - Prior processing information appears incorrect.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
556	CLAIM/DETAIL DENIED. RECIPIENT MUST BE AN INPATIENT IN THE NURSING FACILITY.	556	60	Charges for outpatient services with this proximity to inpatient services are not covered	M2	Not paid separately when patient is an inpatient
557	CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST LINE ANTIHISTAMINE.	557	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
558	H0039 LIMITED TO 32 UNITS PER DAY.		119	Benefit maximum for this time period has been reached.		
559	CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC.	559	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	560	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.	267	A1	Claim denied charges.	N58	Missing/incomplete/invalid patient liability amount.
568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	568	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
569	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	569	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
570	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	570	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
571	PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURING A 365 DAY PERIOD.	571	119	Benefit maximum for this time period has been reached.		
572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PER SIX MONTHS.	572	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
573	DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MONTHS.	573	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
574	CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.	574	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
575	REVENUE CODE INVALID FOR DATES OF SERVICE.	095	A1	Claim denied charges.	M50	Missing/incomplete/invalid revenue code(s).
576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185.	096	60	Charges for outpatient services with this proximity to inpatient services are not covered.	M50	Missing/incomplete/invalid revenue code(s).
577	CLAIM/DETAIL DENIED. PROCEDURE CODES X0100, X0101, AND X0102 CANNOT BE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME RECIPIENT BY THE SAME OR DIFFERENT PROVIDER.	577	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
578	PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURING A 3 YEAR PERIOD.	578	119	Benefit maximum for this time period has been reached.		
			62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER RECIPIENT PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY).	579	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF \$1000.00 PER RECIPIENT FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED.	180, 580	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.
581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF EIGHT UNITS PER RECIPIENT, PER PREGNANCY.	581	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 76 UNITS PER RECIPIENT, PER PREGNANCY.	582	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

<b>KY EOB</b>	<b>MEDICAID DESCRIPTION</b>	<b>MMIS EXCEPTION CODE(S)</b>	<b>HIPAA ADJ RSN CODES</b>	<b>HIPAA ADJ RSN CODE DESCRIPTION</b>	<b>HIPAA REMARK</b>	<b>HIPAA REMARK CODE DESCRIPTION</b>
583	CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 108 UNITS PER RECIPIENT, PER PREGNANCY.	583	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
584	CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 32 UNITS PER RECIPIENT, PER CALENDAR WEEK (SUNDAY THRU SATURDAY).	584	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER RECIPIENT, PER DAY.	585	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
586	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 80 UNITS PER RECIPIENT, PER CALENDAR WEEK (SUNDAY THRU SATURDAY).	586	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 8 UNITS PER RECIPIENT, PER DAY.	587	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
588	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 45 UNITS PER RECIPIENT, PER CALENDAR WEEK (SUNDAY THRU SATURDAY).	588	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
589	CLAIM/DETAIL DENIED. PROCEDURE CODE WB233 NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH WB232 (DATES OF SERVICE WITHIN 30 DAYS OF EACH OTHER).	589	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
590	HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.	590	60	Charges for outpatient services with this proximity to inpatient services are not covered.		
591	CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHABILITATION PROCEDURES.	591	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
592	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHABILITATION PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS OUTPATIENT THERAPIES INDIVIDUAL, GROUP, & FAMILY PROCEDURES.	592	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
593	CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH WB505, WB507, WB508, WB509, WB516, WB521, WB522, WB523, WB526, WB602, WB603 OR WB604 (DATES OF SERVICE WITHIN 30 DAYS OF EACH OTHER).	593	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
594	CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION.	594	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURGICAL PROCEDURE.	596	97	Payment is included in the allowance for another service/procedure.	N19	Procedure code incidental to primary procedure.
597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.	597	97	Payment is included in the allowance for another service/procedure.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
598	CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE.	598	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
599	CLAIM PENDING REVIEW OF HISTORY.	599	133	The disposition of this claim/service is pending further review.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

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600	EYE EXAM LIMITED TO OPTOMETRIST.	600	B5	Payment adjusted because coverage/ program guidelines were not met or were exceeded.		
			8	The procedure code is inconsistent with the provider type/specialty (taxonomy).		
601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS.	601	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER RECIPIENT PER 12 MONTHS	602	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
603	CLAIM DENIED. EACH RECIPIENT ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER.	603	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
604	MORE THAN 2 OF THE COMPONENT TESTS OF A CBC PERFORMED ON THE SAME DOS MUST BE BILLED AS A CBC.	604	A1	Claim denied charges.	N19	Procedure code incidental to primary procedure.
					M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed
605	ONLY FOUR PSYCHIATRIC PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER RECIPIENT.	605	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
606	PROCEDURE CODE 02951 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME RECIPIENT, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER.	606	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
607	EACH RECIPIENT ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER.	607	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
608	CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER CALENDAR MONTH.	639, 651	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
609	CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLUORIDE TREATMENT PER RECIPIENT PER 12 MONTH PERIOD.	609	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
610	CLAIM DENIED. EACH RECIPIENT ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS.	610	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
611	RECIPIENT ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS.	611	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
612	ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER RECIPIENT.	612	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
613	RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS.	613	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
614	RECIPIENT ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE.	614	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
615	MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER RECIPIENT PER CALENDAR YEAR.	615	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
616	MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES PER RECIPIENT PER CALENDAR YEAR.	616	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
617	RECIPIENT ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS.	617	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
618	ONLY ONE DELIVERY ALLOWED PER RECIPIENT/9 MOS.	618	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
619	RECIPIENT ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR.	619	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
620	MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED.	620, 632	119	Benefit maximum for this time period has been reached.		
			62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
621	DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED.	621, 691, 692	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.
622	DETAIL DENIED. ANNUAL LIMIT OF \$500.00 FOR MINOR HOME ADAPTATIONS.	622	45	Charges exceed your contracted/ legislated fee arrangement.		
623	RECIPIENT ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER.	623	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER.	624	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
625	CLAIM DENIED/RECIPIENT ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS.	625, 627	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
626	CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER RECIPIENT.	626	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
627	CLAIM DENIED. RECIPIENT ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS.	626	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
629	RECIPIENT ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS.	629	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
631	RECIPIENTS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS.	631	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
633	CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND NECESSARY PRIOR AUTHORIZATION ON FILE FOR THIS CLAIM.	633	62	Payment denied/reduced for absence of, or exceeded, pre-certification /authorization.		
634	MAXIMUM \$300.00 ALLOWED PER MONTH/RECIPIENT FOR TANK OXYGEN.	634	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.
635	AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER RECIPIENT.	635	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGASSES ALLOW ONE / 12 MOS / RECIPIENT.	636	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
637	CLAIM DENIED. RECIPIENT LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANCES, SEND CLAIM DOCUMENTATION TO DMS FOR REVIEW.	637	119	Benefit maximum for this time period has been reached.	N29	Missing documentation/orders/notes/summary/report/invoice.
638	ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER RECIPIENT PER 9 MONTHS PER CLINIC.	638	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
640	THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS.	355	A2	Contractual adjustment.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication /medical or dental advisor.
641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL.	641	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services.
642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER RECIPIENT PER PROVIDER.	642, 643, 663	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
644	RECIPIENTS ARE LIMITED TO ONE (1) OPHTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS.	644, 664	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
645	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER RECIPIENT PER PROVIDER PER 12 MONTHS.	645, 665	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER RECIPIENT PER PROVIDER PER 12 MONTHS.	646, 666	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
648	RECIP ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS.	648	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
649	RECIP LMTD 1 INITIAL OPHTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS.	649, 669	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
650	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT.	650	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTHS.	652	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
653	CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES.	653	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
654	RECIPIENT ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER.	654	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT PER PROVIDER.	655	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT PER CALENDAR YEAR.	656	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT PER CALENDAR YEAR.	657	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT PER PROVIDER.	658	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER RECIPIENT PER PROVIDER.	659	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
660	MAXIMUM OF 45 RESERVE DAYS PER RECIPIENT PER PROVIDER PER CALENDAR YEAR.	660	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
661	CLAIM DENIED. READMISSION WITHIN 30 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH MEDICAL DOCUMENTATION.	670	119	Benefit maximum for this time period has been reached.	N29	Missing documentation/orders/notes/summary/report/invoice.
			16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.		
662	A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER RECIPIENT.	662	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
665	VENIPUNCTURE/ CATHETERIZATION PROCEDURES 80020, 80022, 80023, 80024, 36415 NOT ALLOWED SAME DOS/ RECIPIENT/PROVIDER.	635	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAVERED OR NON-MICROSCOPY LAB CODE.	512	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER RECIPIENT PER SAME DATE OF SERVICE.	661, 662, 667	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
668	PROCEDURE CODE XR000 IS LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SERVICE.	668	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this days supply.	M139	Denied services exceed the coverage limit for the demonstration.
			119	Benefit maximum for this time period has been reached.		
669	DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT,PER PROVIDER.	669	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
					N43	Bed hold or leave days exceeded.
670	DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER RECIPIENT,PER PROVIDER,PER CALENDAR YEAR.	670	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
					N43	Bed hold or leave days exceeded.
671	MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY.	671	119	Benefit maximum for this time period has been reached.		
673	CPT LEVEL CODE MISSING OR INVALID.	673	A1	Claim denied charges.		
674	PROCEDURE CODE V5020 IS LIMITED TO THREE PER RECIPIENT PER PROVIDER PER SIX MONTHS.	674	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
675	DAYS REDUCED, A MAXIMUM OF 45 TOTAL DAYS PER RECIPIENT, PER PROVIDER, PER CALENDAR QUARTER.	675	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

<b>KY EOB</b>	<b>MEDICAID DESCRIPTION</b>	<b>MMIS EXCEPTION CODE(S)</b>	<b>HIPAA ADJ RSN CODES</b>	<b>HIPAA ADJ RSN CODE DESCRIPTION</b>	<b>HIPAA REMARK</b>	<b>HIPAA REMARK CODE DESCRIPTION</b>
676	PROCEDURE W0030 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090.	676	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
			57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.		
677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS.	677	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
678	RECIPIENTS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHASE I TREATMENT CONTACT DMS FOR FURTHER CONSIDERATION.	678	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER RECIPIENT PER DATE OF SERVICE.	679	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE.	680	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
681	EVEN WITH DOCUMENTATION OF PATIENT'S CONDITION NECESSITATING ADMISSION TO A LESSER FACILITY, REIMBURSEMENT FOR BOTH FACILITIES CANNOT EXCEED A MAXIMUM OF 14 DAYS.	670	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
682	CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION.	670	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
683	MODEL WAIVER RECIPIENTS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE.	683	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
684	MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER RECIPIENT PER DATE OF SERVICE.	684	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME RECIPIENT/SAME DATE(S) OF SERVICE.	685	A1	Claim denied charges.	M86	Service denied because payment already made for similar procedure within set time frame.
					N20	Service not payable with other service rendered on the same date.
686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE DAYS PER RECIPIENT.	686	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
687	UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION.	688	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M53	Missing/incomplete/invalid days or units of service.
688	MODEL WAIVER DOLLAR LIMIT HAS BEEN MET.	688	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
689	RECIPIENTS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH PERIOD.	689	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER RECIPIENT.	690	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
691	CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID.	510	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
692	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAVERED LAB CODE.	511	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
693	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER RECIPIENT PER 12 MONTHS.	693	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
694	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER RECIPIENT PER LIFETIME.	694	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
695	RECIPIENTS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME.	695	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
696	PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-1500.	696	A1	Claim denied charges.	N200	The professional component must be billed separately.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

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697	RECIPIENTS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS.	697	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
698	RECIPIENTS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER LIFETIME.	698	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
700	CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE.	700	52	The referring/prescribing /rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	N55	Procedures for billing with group/referring/performing providers were not followed.
701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER RECIPIENT, PER PROVIDER.	701	119	Benefit maximum for this time period has been reached.	M139 N43	Denied services exceed the coverage limit for the demonstration. Bed hold or leave days exceeded.
702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER RECIPIENT, PER PROVIDER.	702	119	Benefit maximum for this time period has been reached.	M139 N43	Denied services exceed the coverage limit for the demonstration. Bed hold or leave days exceeded.
703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER RECIPIENT, PER PROVIDER.	703	119	Benefit maximum for this time period has been reached.	M139 N43	Denied services exceed the coverage limit for the demonstration. Bed hold or leave days exceeded.
704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER RECIPIENT, PER PROVIDER.	704	119	Benefit maximum for this time period has been reached.	N43	Bed hold or leave days exceeded.
705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	705	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	706	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	707	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER 36 MONTHS/THREE YEARS.	708	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER RECIPIENT, PER PROVIDER.	709	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
710	CLAIM/DETAIL DENIED. ONLY ONE (1) CHEMOTHERAPY ADMIN CODE IS PAYABLE ON THE SAME DATE OF SERVICE. IF QUESTIONS, PLEASE CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.	710	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
711	PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT FORM.	711	A1	Claim denied charges	N51	Electronic interchange agreement not on file for provider / submitter.
713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER RECIPIENT PER DATE OF SERVICE.	712, 713, 714, 720, 721	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
715	CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER RECIPIENT, PER TWO YEARS.	715	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
716	CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER RECIPIENT, PER TWO YEARS.	716	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
717	CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PER PROVIDER, PER RECIPIENT, PER TWO YEARS.	717	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
718	CLAIM DENIED. PROCEDURE CODE X0076 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER RECIPIENT, PER CALENDAR MONTH.	718	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.

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719	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER RECIPIENT, PER CALENDAR YEAR.	719	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
722	CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME RECIPIENT, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER.	722	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER RECIPIENT, PER PROVIDER, PER DATE OF SERVICE, PER TOOTH NUMBER.	723	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
724	CLAIM DETAIL DENIED. PROCEDURE CODE X0095 LIMITED TO \$1000.00 IN PAYMENTS PER SIX MONTHS.	724	45	Charges exceed your contracted/ legislated fee arrangement.	M139	Denied services exceed the coverage limit for the demonstration.
725	PROCEDURE CODES X0050 AND X0150 ARE LIMITED TO 12 UNITS OF SERVICE PER DAY, PER RECIPIENT, PER PROVIDER.	725	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER RECIPIENT, PER PROVIDER, EVERY TWO YEARS.	726	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER RECIPIENT, PER LIFETIME.	727	35	Lifetime benefit maximum has been reached.		
728	GINGIVECTOMY PROCEDURE CODE 04211 IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER TOOTH NUMBER PER 12 MONTHS.	728	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
729	PIN RETENTION THERAPY TREATMENT PROCEDURE CODE 02951 IS LIMITED TO TWO PER RECIPIENT PER PERMANENT MOLAR PER LIFETIME.	729	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
730	PROCEDURE CODE 07880 LIMITED TO ONE PER LIFETIME PER RECIPIENT.	730	35	Lifetime benefit maximum has been reached.		
731	RECIPIENTS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS.	631	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
732	PROCEDURE CODES 07310 AND 07320 ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT, PER RECIPIENT, PER LIFETIME.	732	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
733	PROCEDURE CODE 04210 LIMITED TO FOUR PER RECIPIENT, PER PROVIDER, PER TWELVE MONTHS.	733	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
734	CLAIM/DETAIL DENIED. PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS PROCEDURE CODE 01351.	734	97	Payment is included in the allowance for another service/procedure.	N81	Procedure billed is not compatible with tooth surface code.
735	CLAIM/DETAIL DENIED. INSULIN SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER RECIPIENT.	735	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER RECIPIENT, PER PROVIDER, PER DATE OF SERVICE.	736	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
737	CLAIM/DETAIL DENIED. PROCEDURE CODE 01351 IS LIMITED TO ONE PER TOOTH PER FOUR YEARS PER RECIPIENT.	737	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
738	CLAIM/DETAIL DENIED. PROCEDURE CODE 01351 IS LIMITED TO THREE PER TOOTH PER LIFETIME PER RECIPIENT.	738	35	Lifetime benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
739	CLAIM/DETAIL DENIED. PROCEDURE CODE 01351 IS NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING.	739	97	Payment is included in the allowance for another service/procedure.	N81	Procedure billed is not compatible with tooth surface code.
740	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE PER PRIOR AUTHORIZATION.	740	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
741	CLAIM DENIED. RECIPIENT LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICAL NECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATE MEDICAL NECESSITY.	741	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	M139	Denied services exceed the coverage limit for the demonstration.
					M76	Missing/incomplete/invalid diagnosis or condition.
742	DETAIL DENIED. PROCEDURE CODE 00210 LIMITED TO ONE UNIT PER RECIPIENT, PER PROVIDER, PER 12 MONTHS.	742	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
743	PROCEDURE CODE 04211 LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER RECIPIENT, PER PROVIDER.	743	119	Benefit maximum for this time period has been reached.	M90	Not covered more than once in a 12 month period.
744	CLAIM/DETAIL DENIED. PROCEDURE CODES XH100, X0058, 99199, AND 99499 ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF STATE. CHECK THE UNITS OF SERVICE BILLED FOR ERRORS.	744	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.
745	CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PROVIDER AND A COMMUNITY MENTAL HEALTH PROVIDER ON THE SAME DATE OF SERVICE.	745	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M63	We do not pay for more than one of these on the same day.
746	REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE.	146	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	MA66	Incomplete/invalid principal procedure code and/or date.
747	CLAIM DETAIL DENIED. PROCEDURE CODES X0078, X0079, AND X0098 (ANY COMBINATION) LIMITED TO FORTY HOURS PER SEVEN DAY PERIOD.	747	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE.	148	5	The procedure code/bill type is inconsistent with the place of service.	MA66	Missing/incomplete/invalid principal procedure code or date.
749	CLAIM DETAIL DENIED. PROCEDURE CODE X0063 LIMITED TO 168 HOURS PER SIX MONTHS.	749	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
750	DRUG/DRUG INTERACTION.	750	96	Non-covered charge(s).	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount
751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE.	151	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).
752	REVENUE CODE MISSING/INVALID.	152	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).
753	INVALID REVENUE CODE. CHARGES NOT ALLOWED.	146, 148, 151, 152, 510	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M50	Missing/incomplete/invalid revenue code(s).
754	EARLY REFILL.	754			N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount
755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AFTER, DRUGS MUST BE BILLED BY MEDICAID PARTICIPATING PHARMACY.	755	A1	Claim denied charges.	N95	This provider type/provider specialty may not bill this service.
756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.	756	96	Non-covered charge(s).	MA120	Missing/incomplete/invalid CLIA certification number.
757	CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RT ARE BILLED FOR THE SAME DATES OF SERVICE.	757	96	Non-covered charge(s).		
758	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON-COVERED.	758	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
759	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. CHARGES MOVED TO NON-COVERED.	759	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
760	INFERRED DRUG/DISEASE PRECAUTION.	760	96	Non-covered charge(s).		
761	DRUG/AGE PRECAUTION.	761	96	Non-covered charge(s).		
762	MEDICAL CONDITION ALERT.	762	96	Non-covered charge(s).		

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
763	SERVICES RENDERED DO NOT MEET DMS CRITERIA FOR DENTAL EMERGENCY.	180	40	Charges do not meet qualifications for emergent/urgent care.		
764	DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR DENTAL EMERGENCY.	180	40	Charges do not meet qualifications for emergent/urgent care.	N29	Missing documentation/orders/notes/summary/report/invoice.
765	THERAPEUTIC DUPLICATION.	765	96	Non-covered charge(s).		
766	?		96	Non-covered charge(s).		
767	INGREDIENT DUPLICATION.	767	96	Non-covered charge(s).		
768	ALCOHOL PRECAUTION.	768	96	Non-covered charge(s).		
769	BREAST FEEDING PRECAUTION.	769	96	Non-covered charge(s).		
770	DRUG/FOOD INTERACTION.	770	96	Non-covered charge(s).		
771	DRUG/LAB CONFLICT.	771	96	Non-covered charge(s).		
772	CALL HELP DESK (1-800-807-1232).	772	96	Non-covered charge(s).		
773	INVALID DUR CONFLICT CODE.	773	96	Non-covered charge(s).		
774	INVALID DUR INTERVENTION CODE.	774	96	Non-covered charge(s).		
775	INVALID DUR OUTCOME CODE.	775	96	Non-covered charge(s).		
777	CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS.	777	A1	Claim denied charges.	M117	Not covered unless supplier files an electronic media claim (EMC).
791	CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY).	791	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
792	CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD.	792	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
793	CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.	793	119	Benefit maximum for this time period has been reached.		
794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER RECIPIENT.	794	119	Benefit maximum for this time period has been reached.		
795	CLAIM/DETAIL DENIED. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	795	119	Benefit maximum for this time period has been reached.		
796	CLAIM/DETAIL DENIED. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	796	119	Benefit maximum for this time period has been reached.		
797	EOB IS NOT ON EXCEPTION CONTROL FILE	797				
798	PROCEDURE CODE XZ299 IS LIMITED TO \$150.00 PER CALENDAR MONTH PER RECIPIENT, PER PROVIDER.	798	119	Benefit maximum for this time period has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
799	REVENUE CODE 270 CANNOT EXCEED \$2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH.	799	45	Charges exceed your contracted/ legislated fee arrangement.	M54	Missing/incomplete/invalid total charges.
800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVICE AS X0076.	800	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0074 OR X0075.	801	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
802	PROCEDURE CODE 00150 DISALLOWED BY SAME PROVIDER FOR SAME RECIPIENT ON THE SAME DATE OF SERVICE AS PROCEDURES 09110 OR 00140.	802, 803	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M80	Not covered when performed during the same session/date as a previously processed service for the patient.
					M86	Service denied because payment already made for similar procedure within set time frame.
803	RECIPIENT APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271.	103, 803	133	The disposition of this claim/service is pending further review.	N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

<b>KY EOB</b>	<b>MEDICAID DESCRIPTION</b>	<b>MMIS EXCEPTION CODE(S)</b>	<b>HIPAA ADJ RSN CODES</b>	<b>HIPAA ADJ RSN CODE DESCRIPTION</b>	<b>HIPAA REMARK</b>	<b>HIPAA REMARK CODE DESCRIPTION</b>
808	MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATE OF SERVICE AS DAILY DIALYSIS PROCEDURE CODES.	808, 809	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
810	HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATES OF SERVICE AS EVALUATION AND MANAGEMENT PROCEDURE CODES.	810, 811	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME RECIPIENT WHEN BILLING PROCEDURE 07910.	812, 813	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
814	CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0063, X0096, OR XL307.	814	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
815	CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS COMMUNITY RESIDENTIAL SERVICES.	815	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROCEDURES, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROCEDURES TO THE DMS FOR REVIEW.	816, 817	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.
					M63	We do not pay for more than one of these on the same day.
818	VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.	551, 818, 819	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
820	BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE ENTERED IN FIELD 19.	820			M68	Missing/incomplete/invalid attending or referring physician identification.
					M57	Missing/incomplete/invalid provider identifier.
821	CLAIM DETAIL DENIED. LIMITATION EXCEEDED, PRIOR AUTHORIZATION REQUIRED.	821	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.		
822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF (00210) INTRAORAL COMPLETE SERIES.	822, 823	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for similar procedure within set time frame.
824	DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OTHER PROCEDURE CODES IF BILLED FOR THE SAME RECIPIENT BY THE SAME PROVIDER.	824	119	Benefit maximum for this time period has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
825	DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF 08670 IF BILLED FOR THE SAME RECIPIENT BY THE SAME PROVIDER.	825	97	Payment is included in the allowance for another service/procedure.	M86	Service denied because payment already made for similar procedure within set time frame.
826	PROCEDURE CODE 09110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTAL PROCEDURE CODES FOR THE SAME DATE OF SERVICE.	826	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
827	THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE 09110 FOR THE SAME DATE OF SERVICE.	827	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
					M86	Service denied because payment already made for similar procedure within set time frame.
828	CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIALTY CODE.	828	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).
829	CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PROVIDED TO KCHIP PHASE III RECIPIENTS.	829	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.		
830	NO DRG FOUND	830	147	Provider contracted/ negotiated rate expired or not on file.		
831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.	831	A8	Claim denied; ungroupable DRG	MA63	Missing/incomplete/invalid principal diagnosis.
			96	Non-covered charge(s).		
832	CLAIM DENIED. DRG CRITERIA NOT MET.	832	A8	Claim denied; ungroupable DRG		
			96	Non-covered charge(s).		
833	CLAIM DENIED. DRG INVALID AGE.	833	A8	Claim denied; ungroupable DRG		
			9	The diagnosis is inconsistent with the patient's age.		
			96	Non-covered charge(s).		
834	DRG INVALID SEX.	834	A8	Claim denied; ungroupable DRG		
			10	The diagnosis is inconsistent with the patient's gender.		
			96	Non-covered charge(s).		
835	DRG INVALID DISCHARGE STATUS.	835	A8	Claim denied; ungroupable DRG	N50	Missing/incomplete/invalid discharge information.
			96	Non-covered charge(s).		
836	DRG INVALID PRINCIPLE DIAGNOSIS.	836	A8	Claim denied; ungroupable DRG	MA63	Missing/incomplete/invalid principal diagnosis.
			96	Non-covered charge(s).		
837	CLAIM DENIED. DRG DENY 469 THROUGH 470	837	A8	Claim denied; ungroupable DRG		
			96	Non-covered charge(s).		
838	RESERVED FOR DRG		96	Non-covered charge(s).		
839	RESERVED FOR DRG		96	Non-covered charge(s).		
840	PROCEDURE CODE HAS BEEN REBUNDLED.	840	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
					N19	Procedure code incidental to primary procedure.
842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE.	842	96	Non-covered charge(s).	MA66	Missing/incomplete/invalid principal procedure code or date.
843	PROCEDURE CODE IS INCIDENTAL.	843	96	Non-covered charge(s).	N19	Procedure code incidental to primary procedure.
					M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT.	844	97	Payment is included in the allowance for another service/procedure.	N19	Procedure code incidental to primary procedure.
					M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
845	VISIT IS WITHIN ONE DAY PRE OP RANGE.	845	97	Payment is included in the allowance for another service/procedure.	M144	Pre-/post-operative care payment is included in the allowance for surgery / procedure.
846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE	846	97	Payment is included in the allowance for another service/procedure.		
847	PROCEDURE IS A BILATERAL OR DUPLICATE	847	18	Duplicate claim/service.		
848	PLEASE PAY SPECIFIED PROCEDURE CODES.	848				
849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON.	849	54	Multiple physicians/ assistants are not covered in this case.		
850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE.	850, 852	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.
851	PROCEDURE CODE IS INVALID FOR PATIENTS SEX.	852	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
852	GMIS - INAPPROPRIATE PROCEDURE CODE FOR RECIPIENT'S AGE.	850, 852	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.
853	PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS	850, 852	96	Non-covered charge(s).		
			6	The procedure/revenue code is inconsistent with the patient's age.		
854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS.	850	6	The procedure/revenue code is inconsistent with the patient's age.		
856	PROCEDURE NOT INDICATED FOR A MALE	856	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.
857	PROCEDURE NOT INDICATED FOR A FEMALE	856	7	The procedure/revenue code is inconsistent with the patient's gender.	MA66	Missing/incomplete/invalid principal procedure code or date.
858	CLAIM DENIED. COSMETIC PROCEDURE.	858	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.		
859	CLAIM DENIED. DUPLICATE PROCEDURE.	846	18	Duplicate claim/service.		
860	CLAIM DENIED. EXPERIMENTAL PROCEDURE.	860	96	Non-covered charge(s).		
861	CLAIM DENIED. OBSOLETE PROCEDURE.	861	96	Non-covered charge(s).	MA66	Missing/incomplete/invalid principal procedure code or date.
863	PROCEDURE CODES DOES NOT REQUIRE AN Assistant SURGEON	863	54	Multiple physicians/ assistants are not covered in this case.		
864	PROCEDURE CODE IS INVALID FOR LOCATION.	864	5	The procedure code/bill type is inconsistent with the place of service.	MA66	Missing/incomplete/invalid principal procedure code or date.
865	PROCEDURE CODE NEEDS TO BE REPLACED.	865	A1	Claim denied charges.	N19	Procedure code incidental to primary procedure.
					MA66	Missing/incomplete/invalid principal procedure code or date.
866	PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED.	866	A1	Claim denied charges.	N19	Procedure code incidental to primary procedure.
					MA66	Missing/incomplete/invalid principal procedure code or date.
867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED.	867	A1	Claim denied charges.	N19	Procedure code incidental to primary procedure.
					MA66	Missing/incomplete/invalid principal procedure code or date.
879	CLAIM DENIED. PROCEDURE REQUIRES DOCUMENTATION	879	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N29	Missing documentation/orders/notes/summary/report/invoice.
880	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14	880	6	The procedure/revenue code is inconsistent with the patient's age.		
881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.	880	6	The procedure/revenue code is inconsistent with the patient's age.		
882	CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID	882	96	Non-covered charge(s).		
			50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.		
883	CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID.	883	18	Duplicate claim/service.	M86	Service denied because payment already made for similar procedure within set time frame.
					M63	We do not pay for more than one of these on the same day.
					N20	Service not payable with other service rendered on the same date.
884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL	884	96	Non-covered charge(s).		
			55	Claim/service denied because procedure /treatment is deemed experimental/ investigational by the payer.		
885	CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE.	885			N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.
			96	Non-covered charge(s).	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).

**KENTUCKY EOB/ESC CROSSWALK TO HIPAA**

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
886	CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE BILLED.	862, 886	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
888	GMIS-VISIT IS WITHIN THE POST OP RANGE.	888	97	Payment is included in the allowance for another service/procedure.	M144	Pre-/post-operative care payment is included in the allowance for surgery / procedure.
889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE.	889	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis.
890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES.	890	11	The diagnosis is inconsistent with the procedure.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
891	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE DIAGNOSIS CODES.	891	11	The diagnosis is inconsistent with the procedure.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
893	UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT.	893	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.	894	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	M139	Denied services exceed the coverage limit for the demonstration.
895	RELATED HISTORY OF MORE THAN 25 TCNS.	895				
896	CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT.	896	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
897	CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS.	897	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	M57	Missing/incomplete/invalid provider identifier.
898	TOO MANY CLAIMS IN CYCLE	898				
899	DENIED PER PROVIDER REQUEST	899	A1	Claim denied charges.		
900	THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESUBMIT YOUR CLAIM.	900	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM.	901	A1	Claim denied charges.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
					M53	Missing/incomplete/invalid days or units of service.
902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES.	902	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.
903	CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID.	903	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.
904	CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE.	904			N60	A valid NDC is required for payment of drug claim effective Oct 2002
			57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	MA66	Incomplete/invalid principal procedure code and/or date.
905	CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, PLEASE RESUBMIT.	905	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
					M53	Missing/incomplete/invalid days or units of service.
906	PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FILE.	906	B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.	N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

KY EOB	MEDICAID DESCRIPTION	MMIS EXCEPTION CODE(S)	HIPAA ADJ RSN CODES	HIPAA ADJ RSN CODE DESCRIPTION	HIPAA REMARK	HIPAA REMARK CODE DESCRIPTION
907	CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE.	907	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	N60	A valid NDC is required for payment of drug claim effective Oct 2002
908	CLAIM/DETAIL IS DENIED. THE RECIPIENT IS IN A NURSING FACILITY ON THE DATE OF SERVICE.	908	60	Charges for outpatient services with this proximity to inpatient services are not covered.	MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.
909	CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.	909	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services
910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.	910	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	N54	Claim information is inconsistent with pre-certified/authorized services
911	MODIFIER INVALID FOR PROCEDURE CODE BILLED.	911	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
913	CLAIM DENIED. DAYS SUPPLY EXCEEDS 32 DAYS.	913	57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	M53	Missing/incomplete/invalid days or units of service.
914	CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED.	005	119	Benefit maximum for this time period has been reached.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
					M53	Missing/incomplete/invalid days or units of service.
					MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.	915	42	Charges exceed our fee schedule or maximum allowable amount.	M54	Missing/incomplete/invalid total charges.
916	CLAIM/DETAIL DENIED. EPSDT SPECIAL SERVICES CLAIMS NOT PAYABLE FOR THIS RECIPIENT.	916	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
917	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR RECIPIENT'S AGE.	917	6	The procedure/revenue code is inconsistent with the patient's age.	MA66	Missing/incomplete/invalid principal procedure code or date.
918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE.	918	A1	Claim denied charges.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
919	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE RECIPIENT'S 21ST BIRTHDAY.	919	6	The procedure/revenue code is inconsistent with the patient's age.		
921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE.	921	42	Charges exceed our fee schedule or maximum allowable amount.	N48	Claim information does not agree with information received from other insurance carrier.
922	THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM A PAID MEDICARE EOMB.	122	96	Non-covered charge(s).	N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENT'S ACCOUNT NUMBER FIELD ON THE CLAIM.	923	A1	Claim denied charges.	MA113	Incomplet/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeals rights for unprocessable claims, but you may resubmit this claims after you have notified this office of your correct TIN.
924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A RECIPIENT'S 6TH BIRTHDAY MUST BE SPLIT BILLED. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL.	124	A1	Claim denied charges.	N59	Please refer to your provider manual for additional program and provider information.
					N63	Rebill services on separate claim lines.

KENTUCKY EOB/ESC CROSSWALK TO HIPAA

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925	CLAIM/ DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.	925	97	Payment is included in the allowance for another service/procedure.		
926	CLAIMS/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS VENIPUNCTURE AND ARTERIAL PUNCTURE.	926	97	Payment is included in the allowance for another service/procedure.		
927	CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED.	927	A1	Claim denied charges.	MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
					MA112	Missing/incomplete/invalid group practice information.
928	DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED.	928	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
931	CLAIM DENIED. COMPOUND CODE MISSING OR INVALID.	931	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	N60	A valid NDC is required for payment of drug claim effective Oct 2002
933	CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID.	933	A1	Claim denied charges.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
935	DRUG INCOMPATIBILITY ALERT.	751	96	Non-covered charge(s).		
944	LOW DOSE ALERT.	752	96	Non-covered charge(s).		
945	HIGH DOSE ALERT.	753	96	Non-covered charge(s).		
946	LATE REFILL.	755	96	Non-covered charge(s).		
947	MINIMUM DURATION ALERT.	756	96	Non-covered charge(s).		
948	MAXIMUM DURATION ALERT.	757	96	Non-covered charge(s).		
949	DRUG ALLERGY ALERT.	758	96	Non-covered charge(s).		
950	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY RECIPIENTS.	950	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
951	THIS SERVICE IS NOT COVERED BY MEDICAID.	959	96	Non-covered charge(s).		
952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT.	952	B15	Payment adjusted because this procedure/service is not paid separately.		
953	CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER.	953	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.	954	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
955	CLAIM/DETAIL DENIED. PROVIDER SPECIALTY INVALID FOR MODIFIER GT.	955	B18	Payment denied because this procedure code/ modifier was invalid on the date of service or claim submission.	N95	This provider type/provider specialty may not bill this service.
956	THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE.	956	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
957	CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCEDURE CODE	957	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
958	EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST BE BILLED ON COMMUNITY MENTAL HEALTH CENTER CLAIMS.	958	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
					N34	Incorrect claim form for this service.
959	PRIOR ADVERSE DRUG REACTION.	759	96	Non-covered charge(s).		
960	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED TO NON-COVERED.	960	97	Payment is included in the allowance for another service/procedure.	M50	Missing/incomplete/invalid revenue code(s).
961	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE 240. CHARGES MOVED TO NON-COVERED.	961	97	Payment is included in the allowance for another service/procedure.	M50	Missing/incomplete/invalid revenue code(s).
962	PREGNANCY ALERT.	763	96	Non-covered charge(s).		
963	DRUG/GENDER ALERT.	764	96	Non-covered charge(s).		

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964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO RECIPIENTS OVER AGE 21.	964	6	The procedure/revenue code is inconsistent with the patient's age.		
965	CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO RECIPIENTS OVER AGE 20.	965	6	The procedure/revenue code is inconsistent with the patient's age.		
966	CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO RECIPIENTS UNDER AGE 18.	966	6	The procedure/revenue code is inconsistent with the patient's age.		
967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY.	967	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.
968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY.	968	119	Benefit maximum for this time period has been reached.	M63	We do not pay for more than one of these on the same day.
969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD.	969	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD.	970	A1	Claim denied charges.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
971	LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID.	971	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY.	972	A1	Claim denied charges.	M51	Missing/incomplete/invalid procedure code(s) and/or rates.
					N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
973	PROCEDURE CODE 02951 IS LIMITED TO ONE TOOTH PER DETAIL.	973	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.
974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR PROCEDURE CODE 04211.	974	18	Duplicate claim/service.	M53	Missing/incomplete/invalid days or units of service.
					N63	Rebill services on separate claim lines.
975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCEDURE CODE 04211.	975	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.
976	PIN RETENTION THERAPY PROCEDURE 02951 IS LIMITED TO PERMANENT MOLARS ONLY.	976	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
977	TYPE OF BILL INVALID FOR PROVIDER TYPE.	977	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	MA30	Missing/incomplete/invalid type of bill.
978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.	978	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
979	CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTER 7/1/95 MUST BE SUBMITTED ON PAPER.	979	A1	Claim denied charges.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
981	PROVIDER NOT ALLOWED TO BILL CLAIMS ON PAPER.	981	A1	Claim denied charges.	M117	Not covered unless supplier files an electronic media claim (EMC).
982	CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 FOR ADMINISTRATION TO INDICATE VACCINE OBTAINED FROM PRIVATE SOURCE.	982	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier.
984	MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE.	984	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	N48	Claim information does not agree with information received from other insurance carrier.
985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.	985	119	Benefit maximum for this time period has been reached.	M53	Missing/incomplete/invalid days or units of service.
986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE.	986	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.

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987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP.	987	119	Benefit maximum for this time period has been reached.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS.	988	A1	Claim denied charges.	M54	Missing/incomplete/invalid total charges.
					M79	Missing/incomplete/invalid charge.
989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.	989	96	Non-covered charge(s).	M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).
					M53	Missing/incomplete/invalid days or units of service.
					MA66	Missing/incomplete/invalid principal procedure code or date.
990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE RECIPIENT'S THIRD BIRTHDAY.	997	6	The procedure/revenue code is inconsistent with the patient's age.		
991	UB92 CLAIM DOES NOT HAVE ANY DETAIL LINES	991				
992	DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13.	992	8	The procedure code is inconsistent with the provider type.	MA66	Missing/incomplete/invalid principal procedure code or date.
993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE.	993	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
994	CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE AS ADDITIONAL PASSENGER PROCEDURE CODES.	994	97	Payment is included in the allowance for another service/procedure.	N20	Service not payable with other service rendered on the same date.
					M86	Service denied because payment already made for similar procedure within set time frame.
995	ADJUSTMENT IN DENIED STATUS.	995	A1	Claim denied charges.		
996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID.	996	A1	Claim denied charges.	M53	Missing/incomplete/invalid days or units of service.
997	CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN ADJUSTMENT WITH CORRECTED VALID PRESCRIBER LICENSE NUMBER.	906	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
					N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.
998	CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED.	998	133	The disposition of this claim/service is pending further review.		
999	PENDING FOR REVIEW.	999	133	The disposition of this claim/service is pending further review.	MA07	The claim information has also been forwarded to Medicaid for review.