| EOB Code | Description |
|---|---|
| 0001 | PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID. |
| 0002 | THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DATE OF SERVICE. |
| 0003 | PLEASE VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE. |
| 0004 | MEDICARE PAID DATE IS MISSING OR INVALID. |
| 0005 | EACH PROVIDER IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES(HOSP ADM,ER VIS,CONSULT,OV)/MEMBER/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1OF |
| 0006 | THE DISCHARGE DATE IS MISSING OR INVALID. |
| 0007 | TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES. |
| 0008 | CLAIM DENIED REQUEST FOR PAYMENT WAS REC'D BEYOND MEDICAID FILING LMT CLAIMS MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE WHICH |
| 0009 | CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIMWITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION. |
| 0010 | CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT. |
| 0011 | NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN |
| 0012 | ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE. |
| 0013 | DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE. |
| 0014 | CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID. |
| 0015 | CLAIM/DETAIL DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING CONDITIONS - CONGENITAL, HEREDITARY OR DRUG INDUCED |
| 0016 | CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES. |
| 0017 | LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH. |
| 0018 | CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID. |
| 0019 | CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID. |
| 0020 | MEDICARE DOCUMENTATION NOT ATTACHED. |
| 0021 | CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH. |
| 0022 | COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS. |
| 0023 | CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT. |
| 0024 | THE DETAIL BILLED AMOUNT IS MISSING OR INVALID. |
| 0025 | CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE. |
| 0026 | CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT. |
| 0027 | CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM. |
| 0028 | CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT. |
| 0029 | CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFICPROCEDURE CODE AND CRITERIA SET FOR REVIEW. |
| 0030 | CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING. |
| 0031 | CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT. |
| 0032 | CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE. |
| 0033 | NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES |
| 0034 | DENIED BY MEDICARE. |
| 0035 | DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE |
| 0036 | CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM. |
| 0037 | MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE. |
| 0038 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE. |
| 0039 | THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE. |
| 0040 | CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING. |
| 0041 | DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DATE OF SERVICE, PROVIDER, MEMBER. |
| 0042 | CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB. |
| 0043 | CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID. |
| 0044 | CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID. |
| 0045 | TYPE OF BILL INVALID FOR PROVIDER TYPE. |
| 0046 | CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE. |
| 0047 | PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE |
| 0048 | CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROVIDER SERVICES MAN UAL AND RESUBMIT. |
| 0049 | CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED AMOUNT. |
| 0050 | CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT |
| 0051 | PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL. |
| 0052 | ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS. |
| 0053 | CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE. |
| 0054 | CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM |
| 0055 | CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED. |
| 0056 | CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY. |
| 0057 | INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY. |
| 0058 | CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 0059 | CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID. |
| 0060 | CLAIM DENIED. LOCATION CODE INVALID. |
| 0061 | PAID IN FULL BY MEDICAID. |
| 0062 | CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID. |
| 0063 | CLAIM DENIED. LONG TERM CARE FACILITY NUMBER MUST BE ENTERED IN FACILITY ID FIELD. |
| 0064 | THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN. |
| 0065 | DESTINATION CODE IS MISSING/INVALID. |
| 0066 | PRO STICKER/INDICATOR MISSING OR INVALID |
| 0067 | FAMILY PLANNING INDICATOR INVALID. |
| 0068 | AM/PM PICK-UP INDICATOR MISSING OR INVALID. |
| 0069 | TIME OF CALL IN MISSING/INVALID. |
| 0070 | TIME OF PICK UP IS MISSING OR INVALID. |
| 0071 | DESTINATION CODE MISSING/INVALID. |
| 0072 | PICK-UP LOCATION CODE MISSING OR INVALID. |
| 0073 | REFERRED TO 'OTHER' CODE INVALID. |
| 0074 | ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT. |
| 0075 | CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAGE SIZE. |
| 0076 | OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID. |
| 0077 | CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING |
| 0078 | CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID. |

| EOB Code | Description |
|---|---|
| 0079 | CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT=(RATE PER MILE X EXTRA MILES). |
| 0080 | PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE. |
| 0081 | CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID. |
| 0082 | CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID. |
| 0083 | CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID |
| 0084 | CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID. |
| 0085 | CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER |
| 0086 | PROVIDER INELIGIBLE FOR DATE OF SERVICE. PLEASE CONTACT PROVIDER ENROLL MENT AT (877) 838-5085 OR (877) 838-5085 FOR NF OR ICF/MR. |
| 0087 | CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT. |
| 0088 | CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID. |
| 0089 | DETAIL CHARGE MISSING OR INVALID. |
| 0090 | CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID. |
| 0091 | CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE, OR COMPLETION OF A PARTIAL EXAM FOR PROCESSING. |
| 0092 | THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT. |
| 0093 | THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES. |
| 0094 | PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE |
| 0095 | CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM |
| 0096 | MEMBER'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE. |
| 0097 | DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE. |
| 0098 | MEMBER MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM. |
| 0099 | PERSON OBTAINING CONSENT MUST SIGN ON OR AFTER DATE OF MEMBER SIGNATURE BUT PRIOR TO THE STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID. |
| 0100 | DETAIL FROM DATE OF SERVICE MISSING OR INVALID. |
| 0101 | DETAIL TO DATE OF SERVICE MISSING OR INVALID. |
| 0102 | CLAIM DETAIL DENIED. LATE BILLING DATE OF SERVICE PAST ONE YEAR FILING LIMIT. VERIFIES THAT EACH DETAIL OF A CLAIM IS RECEIVED WITHIN 1 YEAR FROM THE DATE OF |
| 0103 | MISSING OR ALTERED MEMBER SIGNATURE OR DATE ON CONSENT FORM IS NOT ACCEPTABLE.CLAIM NOT PAYABLE BY MEDICAID. |
| 0104 | CLAIM DETAIL DENIED. PLEASE RE-SUBMIT WITH DOCUMENT TITLED INVOICE AND/OR MANUFACTURER?S MSRP AND ALL PERTINENT INFORMATION. |
| 0105 | CLAIM DENIED. CLAIM SUBMITTED FOR HEARING AID AND HEARING AID PARTS SHALL REFLECT THE ACTUAL LABORATORY COST OF THE MATERIALS. INVOICE AND CLAIM MUST MATCH. |
| 0106 | INCLUDED IN FLAT FEE FOR MAJOR PROCEDURES. |
| 0107 | INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT |
| 0108 | CONSENT FORM IS INCOMPLETE |
| 0109 | INCORRECT STERLIZATION CONSENT FORM USED. |
| 0110 | CLAIM SUSPENDED FOR REVIEW. |
| 0111 | ADJUSTMENT REQUEST IN PROCESS |
| 0112 | CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YEAR FILINGLIMITATION. PLEASE CALL PROVIDER SERVICES FOR ASSISTANCE. |
| 0113 | CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE. |
| 0114 | REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID. |
| 0115 | PAYMENT APPLIED TO RECEIVABLE. |
| 0116 | DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL. |
| 0117 | CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM. |
| 0118 | OUR RECORDS INDICATE PAID IN FULL BY MEDICARE. |
| 0119 | NOT COVERED UNDER THE PROGRAM EXCEPT UNDER EPSDT. |
| 0120 | LAB PROCESSING CHARGE INCLUDED IN FLAT FEE. |
| 0121 | THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY MEMBER |
| 0122 | THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDICAID WITH A COPY OF THE MEDICARE EOMB. |
| 0123 | CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBER'S 1ST BIRTHDAY. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL. |
| 0124 | CLAIM DENIED. MENTAL HOSPITAL SERVICES ARE NOT PAYABLE FOR MEMBERS AGE 22 THROUGH 64. |
| 0125 | THE TOOTH NUMBER IS MISSING OR INVALID. |
| 0126 | PROCEDURE CODE(S) IS INVALID FOR OTHER THAN ANTERIOR TOOTH NUMBERS. |
| 0127 | CLAIM/DETAIL DENIED. TOOTH SURFACE IS INVALID. |
| 0128 | THE TOOTH NUMBER IS MISSING OR INVALID. |
| 0129 | KYCONV-DESCRIPTION NOT FOUND |
| 0130 | CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. |
| 0131 | CLAIM/DETAIL DENIED. CERTAIN TITLE V PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY. |
| 0132 | SERVICE NOT AUTHORIZED. |
| 0133 | THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION (PA). CURRENTLY, EDITING |
| 0134 | MAP-34 FORM INCOMPLETE. |
| 0135 | CLAIM/DETAIL DENIED. FULL MOUTH DEBRIDEMENT IS ONLY PAYABLE FOR |
| 0136 | PLEASE INDICATE THE CORRECT PLACE OF SERVICE CODE. |
| 0137 | CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHARGES. |
| 0138 | CLAIM DENIED. LOCK-IN MEMBER. |
| 0139 | CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PER MEMBER. |
| 0140 | CLAIM PENDING REVIEW. MEMBER IS A POTENTIAL LOCK-IN MEMBER. |
| 0141 | PROCEDURE CODE MODIFIER MISSING/INVALID. |
| 0142 | CLAIM DENIED. PREGNACY INDICATOR INVALID FOR MEMBERENT AGE OR SEX. |
| 0143 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE. |
| 0144 | SHOULD BE BILLED BY PROVIDER OF SERVICE. |
| 0145 | THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY. |
| 0146 | THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER TYPE. |
| 0147 | PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER. |
| 0148 | THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE. |
| 0149 | THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBER'S AGE. |
| 0150 | THIS PROCEDURE IS INVALID FOR THE MEMBER'S SEX. |
| 0151 | CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE |
| 0152 | PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY KENTUCKY MEDICAID. |
| 0153 | PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 0154 | PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER. |
| 0155 | PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD. |
| 0156 | THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER. |
| 0157 | PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY. |

| EOB Code | Description |
|---|---|
| 0158 | CLAIM DENIED DUE TO INJURY DIAGNOSIS. |
| 0159 | MORE THAN ONE VISIT PER DETAIL DATE OF SERVICE NOT ALLOWED. EACH VISIT MUST BE BILLED AS SEPARATE LINE ITEMS. |
| 0160 | PROCEDURE INVALID FOR TOOTH NUMBER INDICATED. |
| 0161 | CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE. |
| 0162 | CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY. |
| 0163 | CLAIM DETAIL DENIED. EMPLOYEE ID/PERSONAL IDENTIFIER MISSING OR INVALID. |
| 0164 | PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE. |
| 0165 | SECONDARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE. |
| 0166 | CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 0167 | SECONDARY SURGICAL PROCDURE CODE INVALID FOR MEMBERS AGE. |
| 0168 | PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX. |
| 0169 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX |
| 0170 | PRIMARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 0171 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 0172 | SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 0173 | SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DIAGNOSIS CODE |
| 0174 | PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE |
| 0175 | PROVIDER ON REVIEW FOR SECONDARY SURGICAL PROCEDURE |
| 0176 | SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW |
| 0177 | SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW |
| 0178 | EXPECTED DATE OF DELIVERY MUST BE AT LEAST 30 DAYS FROM DATE OF CONSENT. |
| 0179 | CLAIM DENIED-PLEASE RESUBMIT CLAIM WITH REPORT OF PROCEDURE PERFORMED. |
| 0180 | DETAIL PROCEDURE INDICATE AS ON REVIEW. |
| 0181 | RESUBMIT WITH FEDERAL STERILIZATION CONSENT FORM ATTACHED. |
| 0182 | RESUBMIT W/OPERATIVE NOTES OR EXPLANATION OF PROCEDURE. |
| 0183 | RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED. |
| 0184 | RESUBMIT WITH MAP-235 OR MAP-236 ATTACHED IF APPROPRIATE. |
| 0185 | CONSENT FORM MUST BE SIGNED BY MEMBER 30 DAYS PRIOR TO STERILIZATION |
| 0186 | STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY MEMBER. |
| 0187 | STAMPED SIGNATURES ARE UNACCEPTABLE. |
| 0188 | CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RECOMMENDATION, MEDICAL CLEARANCE STATEMENT, AND INVOICE. |
| 0189 | CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATIONPROCEDURE IN CASES OF EMERGENCY SURGERY OR PREMATURE DELIVERY. |
| 0190 | THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. |
| 0191 | THE SECONDARY DIAGNOSIS IS INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. |
| 0192 | THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE. |
| 0193 | THE SECONDARY DIAGNOSIS IS INVALID FOR THE MEMBER'S AGE. |
| 0194 | DIAGNOSIS IS INVALID FOR MEMBER'S SEX. |
| 0195 | THE SECONDARY DIAGONSIS IS INVALID FOR MEMBER SEX. |
| 0196 | THE BILLED DIAGNOSIS IS ON REVIEW. |
| 0197 | CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH, |
| 0198 | DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH. |
| 0199 | CLAIM DETAIL DENIED. REVENUE CODE 360 MUST BE BILLED WITH A SURGICAL PROCEDURE CODE (01000 THROUGH 69999). |
| 0200 | CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS. |
| 0201 | BILLING PROVIDER/NPI NUMBER IS MISSING. |
| 0202 | INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. |
| 0203 | CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER 12/12/94. |
| 0204 | INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES. |
| 0205 | DIAGNOSIS CODE INVALID FOR PROVIDER TYPE |
| 0206 | CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE. |
| 0207 | DETAIL DIAGNOSIS INVALID FOR PATIENT'S AGE. |
| 0208 | THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS |
| 0209 | CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0. |
| 0210 | CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW. |
| 0211 | THIRD DIAGNOSIS CODE IS NOT ON FILE. |
| 0212 | CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID. |
| 0213 | THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM. |
| 0214 | CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW. |
| 0215 | CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS |
| 0216 | CLAIM/DETAIL DENIED. THIRD DIAGNOSIS NOT VALID FOR MEMBER'S SEX. |
| 0217 | THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBER' AGE. |
| 0218 | FOURTH DIAGNOSIS IS INVALID FOR MEMBER'S SEX. |
| 0219 | FOURTH HEADER DIAGNOSIS ON REVIEW. |
| 0220 | SERVICE(S) NOT COVERED BY MEDICAID. PRIMARY DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY. |
| 0221 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE. |
| 0222 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE |
| 0223 | THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE |
| 0224 | CLAIM DENIED. MISSING OR INVALID DIAGNOSIS CODE. |
| 0225 | NO HISTORY MATCH FOUND, PLEASE RESUBMIT. |
| 0226 | CANNOT BEPROCESSED ON THIS CLAIM FORM. |
| 0227 | CLAIM OVERLAPS YOUR FISCAL YEAR END. |
| 0228 | THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE. |
| 0229 | BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE. |
| 0230 | THE CLINIC IS NOT ELIGIBLE FOR THE CLAIM DATES OF SERVICE. |
| 0231 | CLAIM/DETAIL DENIED. BILLING PROVIDER NAME DOES NOT MATCH THE NAME ON PROVIDER FILE. |
| 0232 | CLAIM/DETAIL DENIED. PROVIDER IS ON PREPAYMENT REVIEW. |
| 0233 | UPIN MISSING OR INVALID. |
| 0234 | CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW. |
| 0235 | SERVICE NOT PROVIDED UNDER THE MEDICAID PROGRAM. |
| 0236 | PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER. |
| 0237 | CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE. |

| EOB Code | Description |
|---|---|
| 0238 | CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC. |
| 0239 | DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE. |
| 0240 | MODIFIER 26 OR 50 CANNOT BE BILLED WITH THIS PROCEDURE CODE. |
| 0241 | PENDING CONFIRMATION OF PROVIDER ELIGIBILITY. |
| 0242 | NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26. |
| 0243 | PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS PROVIDER TYPE. |
| 0244 | PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LABORATORY AND X-RAY SERVICES. |
| 0245 | THESE SERVICES MAY BE BILLED ONLY BY A MEMBER'S HOSPICE PROVIDER. |
| 0246 | 80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS 80020-BLOOD COLLECTION VENIPUNCTURE. |
| 0247 | PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIGIBLE FOR THE DATE OF SERVICE, OR NOT LINKED TO AN INDIVIDUAL PHYSICIAN. |
| 0248 | CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM. |
| 0249 | PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT I N FACILITY FOR ALL OF THE TOTAL BILLED DAYS. |
| 0250 | THIS MEMBER IS NOT ON OUR ELIGIBILITY FILE. PLEASE VERIFY MEMBER MAID NUMBER. |
| 0251 | INCORRECT MEMBER IDENTIFICATION NUMBER. |
| 0252 | MEMBER NAME ON CLAIM DOES NOT MATCH MEMBER NAME ON THE MEDICAID ELIGIBILITY DATABASE FOR THE MAID NUMBER SUBMITTED ON YOUR CLAIM. |
| 0253 | OUR RECORDS INDICATE THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE. |
| 0254 | THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES. |
| 0255 | MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES. |
| 0256 | OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIGIBLE FOR MEDICARE. PLEASE BILL MEDICARE FIRST. IF MEDICARE DENIES THIS SERVICE, RESUBMIT WITH PROOF OF DENAL. |
| 0257 | OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE MEMBER IS NOT ELIGIBLE FOR THE SERVICE(S). |
| 0258 | MEDICARE SUSPECT/DENTAL. |
| 0259 | THE MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE. |
| 0260 | CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS MEMBER. MEDICAID CLAIMS ARE NOT REIMBURSIBLE FOR THS M |
| 0261 | OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR T O THE ENDING DATE OF SERVICE. |
| 0262 | MEMBER IS NOT ELIGIBLE ON THE DATE OF SERVICE. |
| 0263 | CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE. |
| 0264 | MEMBER NAME IS MISSING. |
| 0265 | INCORRECT MEMBER IDENTIFICATION NUMBER. |
| 0266 | MEMBER NOT ELIGIBLE FOR WAIVER SERVICES. |
| 0267 | WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME |
| 0268 | MEMBER MAID NUMBER ON CLAIM DOES NOT MATCH THE MEMBER MAID NUMBER ON ATTACHED ELIGIBILITY CARD. |
| 0269 | CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENROLLED IN A WAIVER OR HOSPICE PROGRAM. |
| 0270 | CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER. |
| 0271 | CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OFSERVICE. PLEASE CONTACT DMS AT 1-800-635-2570. |
| 0272 | CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN |
| 0273 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO CERTAIN TOOTH NUMBERS. |
| 0274 | MEMBER TREATMENT AUTHORIZATION INFORMATION NOT FOUND ON INPATIENT HOSPITAL FILE. |
| 0275 | INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID. |
| 0276 | DETAIL DENIED. THIS SERVICE NOT PAYABLE FOR EMPOWER NON-EMERGENCY TRANSPORTATION MEMBERS. |
| 0277 | THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT.CONTACT HPE PROVIDER BILLING INQUIRY FOR ASSISTANCE. |
| 0278 | CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PAYMENT WAS RECEIVED BY MEMBER. |
| 0279 | CLAIM/DETAIL INDICATES MEMBER HAS OTHER INSURANCE BUT NO INSURANCE AMOUNT ENTERED ON CLAIM. |
| 0280 | CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST. |
| 0281 | MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER. |
| 0282 | THE MEMBER HAS MEDICARE PART A. PLEASE BILL MEDICARE. |
| 0283 | OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE. |
| 0284 | OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST. |
| 0285 | 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. |
| 0286 | THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE. |
| 0287 | PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH THE CORRESPONDING TECHNICAL COMPONENT REVENUE CODE. |
| 0288 | PROFESSIONAL COMPONENT REVENUE CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL REVENUE CODE. CHARGES MOVED TO NON-COVERED. |
| 0289 | CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID. |
| 0290 | PENDING CONFIRMATION OF MEMBER ELIGIBILITY. |
| 0291 | PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT. |
| 0292 | CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW. |
| 0293 | CLAIM SUSPENDED FOR ELIGIBILITY REVIEW. |
| 0294 | KENPAC MEMBER. REFERRING PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PRIMARY PHYSICIAN/CLINIC NUMBER FOR THE DATE(S) OF SERVICE. |
| 0295 | 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 EN |
| 0296 | CLAIM DENIED. TYPE OF SERVICE DOES NOT MATCH PROCEDURE MODIFIER. |
| 0297 | MEMBER IS NOT ELIGIBLE FOR HOSPICE. |
| 0298 | MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE. |
| 0299 | HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE. |
| 0300 | SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS |
| 0301 | CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP. |
| 0303 | THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE. |
| 0304 | OFFICE/EMERGENCY NOT COVERED SAME DATE OF SERVICE AS A NORPLANT/REMOVEL. |
| 0305 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS INVALID FOR THE PROVIDER PROFESSIONAL CODE (1ST DIGIT OF MODIFIER). |
| 0306 | A HOSPICE MEMBER - RECYCLE FOR EDIT 298. |
| 0307 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE UNLESS BILLED IN CONJUNCTION WITH OTHER DESIGNATED PROCEDURES. |
| 0308 | DETAIL DENIED. REQUIRED DOCUMENTATION IS MISSING OR DOES NOT VERIFY THAT MEDICAL ASSISTANCE WAS PROVIDED. |
| 0309 | CROSSOVER CLAIM DENIED. HEARING AID PROCEDURE CODES MUST BE BILLED AS NON-CROSSOVER WITH ANY MEDICARE PAYMENT SUBMITTED AS PRIVATE INSURANCE PAYMENT. A COPY |
| 0310 | CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE. |
| 0311 | CORRECTED PAYMENT PER ADJUSTMENT REQUEST. |
| 0316 | CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTED. PLEASE CHECK RECORDS AND VERIFY TOOTH NUMBER. |
| 0319 | INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED. |
| 0320 | CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS. |

| EOB Code | Description |
|---|---|
| 0321 | EPSDT SCREENING PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT RELATED PROCEDURES. |
| 0322 | EPSDT RELATED PROCEDURES ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROCEDURES. |
| 0325 | CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 0326 | CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM. |
| 0327 | PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION. |
| 0328 | PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION. |
| 0329 | SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 0330 | DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED. |
| 0331 | PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE. |
| 0333 | NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION. |
| 0334 | SUPPLY NOT COVERED ON RENTAL ITEM. |
| 0335 | LACKS REPORT TO JUSTIFY HIGHER FEE. |
| 0337 | CATHETERIZATION PROCEDURES 80021,80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROVIDER. |
| 0340 | ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FITTING OF A HEARING AID. |
| 0341 | AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A HOSPITAL ADMISSION. |
| 0342 | AN OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A CONSULTATION. |
| 0343 | CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE |
| 0344 | AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS AN EMERGENCY ROOM VISIT. |
| 0345 | 80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/ MEMBER/PROVIDER AS 80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF. |
| 0347 | DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABLE ON SAME DATE OF SERVICE. |
| 0348 | ROOM CHARGES REDUCED TO SEMI PRIVATE RATE. |
| 0349 | EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS. |
| 0350 | DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DATE OF SERVICE AS EMERGENCY SERVICES OR SEALANTS. |
| 0351 | INCORRECT NUMBER OF DAYS COVERED AND NON-COVERED. |
| 0352 | CLAIM DENIED. INAPPROPRIATE PROCEDURE CODE USED. |
| 0353 | INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWABLE PER ALLERGY TESTING OF SERVICE. |
| 0354 | MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB |
| 0355 | FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT |
| 0356 | CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS. |
| 0357 | CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED. |
| 0359 | REFER TO THE ADJUSTMENT REASON CODE. |
| 0360 | FEE ADJUSTED PER CLAIM CREDIT. |
| 0361 | GENERAL OPHTHALMOLOGICAL SERVICES NOT PAYABLE ON THE SAME DATE OF SERVICE AS SPECIAL OPHTHALMOLOGICAL SERVICES. |
| 0362 | PATIENT LIABILITY APPLIED TO ALLOWED AMOUNT FOR THIS CLAIM. |
| 0363 | ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION |
| 0364 | PAYMENT REDUCED BY OTHER INSURANCE |
| 0365 | FEE ADJUSTED TO MAXIMUM ALLOWABLE. |
| 0366 | CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED $50.00 PER UNIT OF SERVICE. |
| 0367 | THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE. |
| 0368 | REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER. |
| 0369 | ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE. |
| 0370 | PAYMENT MODE NOT FOUND FOR BILLING PROVIDER |
| 0371 | REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE |
| 0372 | HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVALUATION AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE. |
| 0373 | UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY. |
| 0374 | REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINANCIAL ITEMS. |
| 0375 | KYCONV-DESCRIPTION NOT FOUND |
| 0376 | CLAIM DENIED. MAC FIELD INVALID. |
| 0377 | MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM. |
| 0378 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED. |
| 0379 | PAID BY MEDICAID |
| 0380 | CO-PAY WAS DEDUCTED FROM REIMBURSEMENT. |
| 0381 | CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS EMERGENCY ROOM VISIT |
| 0382 | DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN $100.00. |
| 0383 | CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS ABDOMINAL SURGERY. |
| 0384 | DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES. |
| 0385 | CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS A D.& C. PROCEDURE. |
| 0386 | DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT. |
| 0387 | CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE. |
| 0388 | THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO NON-COVERED. |
| 0389 | PAID CLAIM BASED UPON MEDICAL REVIEW. |
| 0390 | CLAIM DENIED. DUPLICATE SERVICE BILLED. |
| 0391 | DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0061/T2016, X0088/S5126, OR X0089/H0043. |
| 0392 | DETAIL DENIED. PROCEDURE CODES X0061, X0088, AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091. |
| 0393 | CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE. |
| 0394 | HOURLY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE SERVICES. |
| 0395 | THE AMOUNT PAID BY OTHER INSURANCE EQUALS OR EXCEEDS THE AMOUNT OF MEDICAID REIMBURSEMENT FOR THIS SERVICE. THE CLAIM IS PAID IN FULL. MEMBER SHALL NOT BEBIL |
| 0396 | DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DATE OF SERVICE AS HOURLY RESPITE SERVICES. |
| 0397 | ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM. |
| 0398 | CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID. |
| 0399 | CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS PE MEMBER. |
| 0400 | DETAIL DENIED. BILLED AMOUNT MUST EQUAL INVOICE AMOUNT PLUS 20 PERCENT. |
| 0402 | DETAIL DENIED. BILLED AMOUNT MUST EQUAL MSRP AMOUNT MINUS 18 PERCENT. |
| 0403 | PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE. |
| 0404 | NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332. |
| 0409 | INVALID PROVIDER TYPE BILLED ON CLAIM FORM. |
| 0410 | FORMAT INVALID FOR ELECTRONIC CLAIMS. PLEASE CONTACT ECS HELP DESK AT 1-800-205-4696. |

| EOB Code | Description |
|---|---|
| 0411 | DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERVICE ON SEPARATE INVOICES - ONE INVOICE FOR EACH MONTH. |
| 0412 | DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 0413 | MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. |
| 0414 | MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE. |
| 0415 | FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE. |
| 0416 | CAPITATION RATE NOT WITHIN DATES OF SERVICE. |
| 0417 | CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR. |
| 0418 | CLAIM DENIED. INVALID ENCOUNTER TYPE. |
| 0419 | CLAIM DENIED. INVALID ENC RECEIPT DATE. |
| 0420 | CLAIM DENIED. INVALID ENC PAYMENT AMOUNT. |
| 0421 | CLAIM DENIED. INVALID ENC PAYMENT DATE. |
| 0422 | CLAIM DENIED. INVALID ENC ADJUSTMENT TCN. |
| 0423 | CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL. |
| 0424 | CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL. |
| 0425 | DETAIL DENIED. PROCEDURE CODE NOT A COVERED SERVICE. |
| 0426 | THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE |
| 0427 | CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE. |
| 0428 | FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE. |
| 0429 | CLAIM DENIED. PARTNERSHIP NUM MISMATCH |
| 0430 | CLAIM DENIED. ENCOUNTER, INV. TCN TO CREDIT |
| 0431 | RESERVED FOR MANAGED CARE. |
| 0432 | CLAIM DENIED. SEQ# MISMATCH ACROSS CLAIM. |
| 0433 | CLAIM DENIED. VOID/RESUB INVALID FOR XOVER. |
| 0434 | RESERVED FOR MANAGED CARE. |
| 0435 | CLAIM/DETAIL DENIED. SCL WAIVER SERVICES ARE ONLY PAYABLE TO THE PRIMARY SCL PROVIDER FOR THIS MEMBER. |
| 0436 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS. |
| 0437 | CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAYS PRIOR TO AN INPATIENT HOSPITAL ADMISSION (AND VICE VERSA). |
| 0438 | CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER MEMBER, PER PROVIDER. |
| 0439 | CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER CALENDAR WEEK, PER MEMBER, PER PROVIDER. |
| 0440 | CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY). |
| 0441 | CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER MEMBER. |
| 0442 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODES 99244 AND 99245. |
| 0443 | CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS CERTAIN OTHER TITLE V PROCEDURE CODES. |
| 0444 | PLEASE CORRECT INVALID OR MISSING NDC NUMBER. |
| 0445 | CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER. |
| 0446 | CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER. |
| 0447 | CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY. |
| 0448 | MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250. |
| 0449 | THE MEMBER ELIGIBILITY MAID NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT. |
| 0450 | CLAIM DETAIL DENIED. ASSESSMENT PROCEDURES ARE LIMITED TO ONE (1) PER MEMBER, PER PROVIDER DURING THE MEMBER'S ASSESSMENT PERIOD ON THE PRIOR AUTHORIZAION FI |
| 0451 | CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROCEDURE LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR AUTHORIZATION FILE. CONTACT PRO. |
| 0452 | CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK. |
| 0453 | CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043, AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY. |
| 0454 | CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY. |
| 0455 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY. |
| 0456 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. |
| 0457 | CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY. |
| 0458 | CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO $150.00 PER DAY. |
| 0459 | CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR. |
| 0460 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY. |
| 0461 | CLAIM/DETAIL DENIED. 97535 LIMITED TO 80 UNITS PER WEEK. |
| 0462 | PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX. |
| 0463 | PAY TPL CLAIM. |
| 0464 | PAY AND BILL TPL CLAIM. |
| 0465 | MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT). |
| 0466 | DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER. |
| 0467 | MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER. |
| 0469 | CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK. |
| 0472 | MEMBERS LIMITED TO ONE DRUG CLASS(GPPC) 681200 PRISCRIPTION/REFILL PER DATE OF SERVICE. |
| 0473 | MEDICAID REIMBURSEMENT FOR THIS DATE OF SERVICE HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO. |
| 0476 | MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE. |
| 0477 | MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE. |
| 0478 | YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION OF THESE DATES OF SERVICE. |
| 0479 | CLAIM DENIED. SERVICES FOR THESE DATES OF SERVICE HAVE BEEN PAID TO A NON-HOSPICE PROVIDER. |
| 0481 | CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED. |
| 0482 | CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED. |
| 0483 | DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST. |
| 0484 | ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER. |
| 0486 | DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM. |
| 0487 | ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS. |
| 0489 | CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER. |
| 0490 | CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY. |
| 0491 | CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE. |
| 0492 | CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE TITLE V SERVICES AND IMPACT PLUS/CHMC SERVICES ON THE SAME DATE OF SERVICE. |
| 0493 | CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH SERVICES FROM TWO DIFFERENT SUB-PROVIDERS ON THE SAME DATE OF SERVICE. |
| 0494 | DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 18TH BIRTHDAY. |
| 0496 | ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER. |
| 0497 | CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON HPE ADJUSTMENT REQUEST FORM. |

| EOB Code | Description |
|---|---|
| 0498 | CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE. |
| 0499 | CLAIM PENDING REVIEW OF HISTORY. |
| 0500 | CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS. |
| 0501 | PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER. |
| 0502 | ONE FAMILY PLANNING SERVICE PER DOS. |
| 0503 | ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINIC. |
| 0504 | FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD. |
| 0505 | MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE. |
| 0506 | CBC AND COMPONENTS NOT ALLOWED SAME DOS. |
| 0507 | PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS. |
| 0508 | COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS. |
| 0509 | MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR PER PROVIDER FOR DOS PRIOR TO SEPT. 1, 1985. |
| 0510 | MEMBERS LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DATE OF SERVICE. |
| 0511 | PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE. |
| 0512 | CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY. |
| 0513 | CLAIM DENIED. FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION. |
| 0514 | CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY. |
| 0515 | CLAIM DENIED CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION. |
| 0516 | EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED. |
| 0517 | CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER. |
| 0518 | CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PROVIDER. USE PROCEDURE 07120 FOR EACH ADDITIONAL TOOTH EXTRACTED |
| 0519 | CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INCLUDED IN DELIVERY FEE. |
| 0520 | MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS. |
| 0521 | COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIVE CLIENT EVALUATION. |
| 0522 | COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME. |
| 0523 | RESIDENTIAL COMPONENT SERVICE NOT ALLOWED WITH IN-HOME SCL SERVICES ON THE SAME DOS. |
| 0524 | IN-HOME SCL SERVICES NOT ALLOWED WITH RESIDENTIAL COMPONENT SERVICES ON THE SAME DOS. |
| 0525 | IN-PATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMISSION. |
| 0526 | IN-PATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO 1 ATTENDANCE AND/OR 1 CONSULTATION PER DATE OF SERVICE PER PROVIDER. |
| 0527 | ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED. |
| 0528 | ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN PROCEDURE OR A FRACTURED INCISAL BUILD-UP. |
| 0529 | CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE BEEN PAID FOR THE SAME TOOTH SAME DOS. |
| 0530 | CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE. |
| 0531 | PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM. |
| 0532 | RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM. |
| 0533 | CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATION. |
| 0534 | CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER PROCEDURE CODES. |
| 0535 | PLEASE BILL BABY'S HOSPITAL STAY AFTER MOTHER'S DISCHARGE ON SEPARATE CLAIM FORM, USING BABY'S OWN NAME AND NUMBER. |
| 0536 | THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIGINAL EOMB INDICATING THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS. |
| 0537 | CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI |
| 0538 | CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION. NO |
| 0539 | CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVICE PRIOR AUTHORIZED. |
| 0540 | HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AUTHORIZED THROUGH EPSDT SPECIAL SERVICES. |
| 0541 | CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. PLEASE RESUBMITFOR ADJUSTMENT WITH PAID RA OF CAST APPLICATION OR REMOVAL AND CORRECTED CLAIM |
| 0542 | DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS. |
| 0543 | 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 FORWAR |
| 0544 | CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS. |
| 0545 | MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DATE OF SERVICE MUST BE BILLED ON SAME CLAIM. FILE AN ADJUSTMENT TO ADD ADDITIONAL PROCEDURES TO RELATED PA |
| 0546 | CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) MONTHS OLD. |
| 0547 | CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED. |
| 0548 | CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185. |
| 0549 | CLAIM/DETAIL DENIED. THIS PROCEDURE SHALL NOT BE PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED. CONTACT THE DEPT. FOR MEDICAID SERVICES FOR CLARI |
| 0550 | PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, AND SAME DATE OF SERVICE. |
| 0551 | DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY. |
| 0552 | THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY. |
| 0553 | CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATED. |
| 0554 | THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT. |
| 0555 | PLEASE ATTACH THE PART B MEDICARE EXPLANATION OF BENEFITS AND REBILL. |
| 0556 | CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY. |
| 0557 | CLAIM DENIED. SECOND LINE ANTIHISTAMINE NOT PAYABLE WITHIN FIVE DAYS OF A FIRST LINE ANTIHISTAMINE. |
| 0558 | CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY. |
| 0559 | CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC. |
| 0560 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 0567 | CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE. |
| 0568 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. . |
| 0569 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 0570 | DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 0571 | CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURING A 365 DAY PERIOD. |
| 0572 | DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PERSIX MONTHS. |
| 0573 | DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MONTHS. |
| 0574 | CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED. |
| 0575 | REVENUE CODE INVALID FOR DATES OF SERVICE. |
| 0576 | ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185. |

| EOB Code | Description |
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| 0577 | CLAIM DETAIL DENIED. PROCEDURE CODES X0100/H0043 AND X0101/T2016 CANNOT BE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER BY THE SAME OR DIFFERENTPRO |
| 0578 | CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURING A 3 YEAR PERIOD. |
| 0579 | CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY). |
| 0580 | CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF $1000.00 PER MEMBER FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED. |
| 0581 | CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF EIGHT UNITS PER MEMBER, PER PREGNANCY. |
| 0582 | CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 76 UNITS PER MEMBER, PER PREGNANCY. |
| 0583 | CLAIM/DETAIL DENIED. INDICATED PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 108 UNITS PER MEMBER, PER PREGNANCY. |
| 0584 | CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 32 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SAURD |
| 0585 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER MEMBER, PER DAY. |
| 0586 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 160 UNITS PER MEMBER, PER CALENDAR WEEK |
| 0587 | CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 8 UNITS PER MEMBER, PER DAY. |
| 0588 | CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 45 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SATURDAY). |
| 0589 | CLAIM/DETAIL DENIED. SUBSTANCE ABUSE COMMUNITY SUPPORT NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH SUBSTANCE ABUSE CASE MANAGEMENT (DATES OF SERVICE WITHIN0 |
| 0590 | HOSPITAL OUTPATIENT SERVICES NON-PAYABLE DURING A HOSPITAL INPATIENT STAY. |
| 0591 | CLAIM/DETAIL DENIED. OUTPATIENT THERAPIES INDIVIDUAL, GROUP, AND FAMILY PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS INTENSIVE OUTPATIENT S |
| 0592 | CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT SERVICES NON-RESIDENTIAL AND DAY REHABILITATION PROCEDURE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS OUTPA |
| 0593 | CLAIM DENIED. THIS PROCEDURE IS NOT PAYABLE UNLESS BILLED IN CONJUNTION WITH WB505, WB516, WB526/90862(UD), WB507, WB521, WB602/90804(UD), WB508, WB522, WB60 |
| 0594 | CLAIM DENIED. CLAIM EXCEEDS 140 DAY ACID/PEPTIC THERAPY LIMITATION. |
| 0596 | CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURGICAL PROCEDURE. |
| 0597 | CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY. |
| 0598 | CLAIM DETAIL DENIED. ONLY ONE 'E AND M' CODE ALLOWED PER DATE OF SERVICE. |
| 0599 | CLAIM PENDING REVIEW OF HISTORY. |
| 0600 | EYE EXAM LIMITED TO OPTOMETRIST. |
| 0601 | ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS. |
| 0602 | CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER PER 12 MONTHS |
| 0603 | CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY 2 YEARS PER PROVIDER. |
| 0604 | NOT MORE THAN TWO (2) COMPONENT TESTS OF A CBC ARE ALLOWED PER MEMBER ON THE SAME DATE OF SERVICE. |
| 0605 | ONLY FOUR MENTAL HEALTH/SUBSTANCE ABUSE PROCEDURES ALLOWED PER YEAR, PER PROVIDER, PER MEMBER. |
| 0606 | PIN RETENTION CAN ONLY BE BILLED ALONE OR WITH MONITORED PROCEDURE CODES FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND SAME TOOTH NUMBER. |
| 0607 | EACH MEMBER ALLOWED 4 SINGLE BITEWING X-RAYS PER 12 MONTHS PER PROVIDER. |
| 0608 | CLAIM DENIED. THIS SERVICE IS LIMITED TO ONE PER MEMBER, PER PROVIDER,PER CALENDAR MONTH. |
| 0609 | CLAIM DENIED. ONE DENTAL PROPHYLAXIS/FLOURIDE TREATMENT PER MEMBER PER 12 MONTH PERIOD. |
| 0610 | CLAIM DENIED. EACH MEMBER ALLOWED ONE UPPER TRANSITIONAL APPLIANCE PER 12 MONTHS. |
| 0611 | MEMBER ALLOWED THREE TRANSITIONAL APPLIANCE REPAIRS PER 12 MONTHS. |
| 0612 | ONLY 9 UNITS (ADULT DAY HABILITATION) ALLOWED PER DATE OF SERVICE PER MEMBER. |
| 0613 | RESIDENTIAL RESPITE DAILY SERVICE ALLOWED FOR ONLY 30 CONSECUTIVE DAYS. |
| 0614 | MEMBER ALLOWED ONLY 30 CONSECUTIVE DAY OF IN-HOME RESPITE DAILY SERVICE. |
| 0615 | MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR. |
| 0616 | MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR. |
| 0617 | MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS. |
| 0618 | ONLY ONE DELIVERY ALLOWED PER MEMBER/9 MOS. |
| 0619 | MEMBER ALLOWED POST-PARTUM CARE 2 TIMES PER YEAR. |
| 0620 | CLAIM DENIED. MAXIMUM DAILY DOSE EXCEEDED - PRIOR AUTHORIZATION REQUIRED. |
| 0621 | DETAIL DENIED. MAXIMUM DOLLAR AMOUNT FOR COMMUNITY BASED SERVICES RESPITE SERVICE HAS BEEN EXCEEDED. |
| 0622 | DETAIL DENIED. ANNUAL LIMIT OF $500.00 FOR MINOR HOME ADAPTIONS. |
| 0623 | MEMBER ALLOWED 14 SINGLE INTRAORAL PERIAPICAL RADIOGRAPHS PER 12 MOS PER PROVIDER. |
| 0624 | CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER. |
| 0625 | CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS. |
| 0626 | CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER. |
| 0627 | CLAIM DENIED. MEMBER ALLOWED 3 REPAIRS TO BROKEN DENTURES PER 12 MONTHS. |
| 0629 | MEMBER ALLOWED 1 LOWER TRANSITIONAL APPLIANCE PER 12 MONTHS. |
| 0631 | MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS. |
| 0632 | FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY. |
| 0633 | CLAIM DENIED. BRAND NECESSARY PRIOR AUTHORIZATION REQUIRED. NO MATCHING BRAND NECESSARY PRIOR AUTHORIZATION ON FILE FOR THIS CLAIM. |
| 0634 | MAXIMUM $300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN. |
| 0635 | AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER. |
| 0636 | PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW ONE / 12 MOS /MEMBER. |
| 0637 | CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANCES, SEND CLAIM DOCUMENTATION TO DMS FOR REVIEW. |
| 0638 | ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CLINIC. |
| 0640 | THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS. |
| 0641 | PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL. |
| 0642 | THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER. |
| 0644 | MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS. |
| 0645 | NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS. |
| 0646 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS. |
| 0648 | MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS. |
| 0649 | MEMBER LMTD 1 INITIAL OPTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS. |
| 0650 | ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT. |
| 0652 | CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO FOUR PER 12 MONTHS. |
| 0653 | CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES. |
| 0654 | MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER. |

| EOB Code | Description |
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| 0655 | MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER. |
| 0656 | MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR. |
| 0657 | MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR. |
| 0658 | MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER. |
| 0659 | MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER. |
| 0660 | MAXIMUM OF 45 RESERVE DAYS PER MEMBER PER PROVIDER PER CALENDAR YEAR. |
| 0661 | CLAIM DENIED. READMISSION WITHIN 14 DAYS OF LAST DISCHARGE DATE/THROUGH DATE. PLEASE RESUBMIT WITH DOCUMENTATION NECESSITATING READMISSION ALONG WITH BOTH DIS |
| 0662 | A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBER. |
| 0665 | VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020,80022,80023, 80024,36415 NOT ALLOWED SAME DOS/MEMBER/PROVIDER. |
| 0666 | CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. |
| 0667 | THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE. |
| 0668 | DAY CARE SERVICES ARE LIMITED TO NO MORE THAN 2 UNITS OF SERVICE PER DATE OF SERVICE. |
| 0669 | DAYS REDUCED, A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER. |
| 0670 | DAYS REDUCED, A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER,PER PROVIDER,PER CALENDAR YEAR. |
| 0671 | CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY. |
| 0673 | CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID. |
| 0674 | PROCEDURE CODE V5020 IS LIMITED TO THREE PER MEMBER PER PROVIDER PER SIX MONTHS. |
| 0675 | CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 60 DAYS. |
| 0676 | PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090. |
| 0677 | PROCEDURE CODE LIMITED TO ONE PER 60 DAYS. |
| 0678 | MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHASE I TREATMENT CONTACT DMS FOR FURTHER CONSIDERATION. |
| 0679 | CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE. |
| 0680 | FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE. |
| 0681 | CLAIM DENIED. THIS HOSPITALIZATION IS RELATED TO A PREVIOUSLY PAID ADMISSION. |
| 0682 | CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION. |
| 0683 | MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE. |
| 0684 | MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE OF SERVICE. |
| 0685 | CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE. |
| 0686 | CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE DAYS PER MEMBER. |
| 0687 | UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION. |
| 0688 | MODEL WAIVER DOLLAR LIMIT HAS BEEN MET. |
| 0689 | MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH PERIOD. |
| 0690 | CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER MEMBER. |
| 0691 | CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID. |
| 0692 | CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. |
| 0693 | COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS. |
| 0694 | COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME. |
| 0695 | MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME. |
| 0696 | CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-1500. |
| 0697 | MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS. |
| 0698 | MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER LIFETIME. |
| 0699 | CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $260.00 IN |
| 0700 | CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE. |
| 0701 | CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER MEMBERIE |
| 0702 | CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER. |
| 0703 | CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR YEAR, PER MEMBER, PER PROVIDER. |
| 0704 | CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER MEMBER, PER PROVIDER. |
| 0705 | NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS. |
| 0706 | NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PRO VIDER, PER 36 MONTHS/THREE YEARS. |
| 0707 | NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS. |
| 0708 | NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS. |
| 0709 | CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER. |
| 0710 | 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 S |
| 0711 | PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT FORM. |
| 0712 | CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO $265.00 PER CALENDAR MONTH. |
| 0713 | DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER MEMBER PER DATE OF SERVICE. |
| 0715 | CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS. |
| 0716 | CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS. |
| 0717 | CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS. |
| 0718 | CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER CALENDAR MONTH. |
| 0719 | CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER MEMBER, PER CALENDAR YEAR. |
| 0722 | CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROVIDER, SAME DATE OF SERICE |
| 0723 | CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER, PER DATE OF SERVICE, PER TOOTH NUMBER. |
| 0724 | CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO $1000.00 IN PAYMENTS PERSIX MONTHS. |
| 0725 | INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY,PER MEMBER,PER PROVIDER. |
| 0726 | CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVIDER, EVERY TWO YEARS. |
| 0727 | CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFETIME. |
| 0728 | GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NUMBER PER 12 MONTHS. |
| 0729 | PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLAR PER LIFETIME. |
| 0730 | PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER. |
| 0731 | MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS. |
| 0732 | ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE PER QUADRANT, PER MEMBER, PER LIFETIME. |
| 0733 | PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EACH PER QUADRANT, PER MEMBER, PER 12 MONTH PERIOD, PER PROVIDER. |
| 0734 | CLAIM/DETAIL DENIED.PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT. |
| 0735 | CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER. |
| 0736 | CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PROVIDER, PER DATE OF SERVICE. |

| EOB Code | Description |
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| 0737 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO ONE PER TOOTH PER FOUR YEARS PER MEMBER. |
| 0738 | CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER. |
| 0739 | CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING. |
| 0740 | CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE PER PRIOR AUTHORIZATION. |
| 0741 | CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICAL NECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATEMED |
| 0742 | DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 12 MONTHS. |
| 0743 | GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVIDER. |
| 0744 | CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF SERVICE. PLEASE CHECK THE UNITS OF SERVICE BILLED FOR ERRORS |
| 0745 | 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. |
| 0746 | REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE. |
| 0747 | CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS PER CALENDAR WEEK. |
| 0748 | REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE. |
| 0749 | CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS. |
| 0750 | DRUG/DRUG INTERACTION. |
| 0751 | REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 0752 | REVENUE CODE MISSING/INVALID. |
| 0753 | INVALID REVENUE CODE. CHARGES NOT ALLOWED. |
| 0754 | EARLY REFILL. |
| 0755 | NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AFTER, DRUGS MUST BE BILLED BY MEDICAID PARTICIPATING PHARMACY. |
| 0756 | CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED. |
| 0757 | CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RTARE BILLED FOR THE SAME DATES OF SERVICE. |
| 0758 | PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON-COVERED. |
| 0759 | PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. CHARGES MOVED TO NON-COVERED. |
| 0760 | INFERRED DRUG/DISEASE PRECAUTION. |
| 0761 | DRUG/AGE PRECAUTION. |
| 0762 | MEDICAL CONDITION ALERT. |
| 0763 | SERVICES RENDERED DO NOT MEET DMS CRITERIA |
| 0764 | DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED. |
| 0765 | THERAPEUTIC DUPLICATION. |
| 0766 | REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED. |
| 0767 | INGREDIENT DUPLICATION. |
| 0768 | ALCOHOL PRECAUTION. |
| 0769 | BREAST FEEDING PRECAUTION. |
| 0770 | DRUG/FOOD INTERACTION. |
| 0771 | DRUG/LAB CONFLICT. |
| 0772 | CALL HELP DESK (1-800-807-1232). |
| 0773 | INVALID DUR CONFLICT CODE. |
| 0774 | INVALID DUR INTERVENTION CODE. |
| 0775 | INVALID DUR OUTCOME CODE. |
| 0777 | CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS. |
| 0778 | VARIANCE LIMIT MET. CLAIM PENDING REVIEW. |
| 0781 | CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL SPEECH THERAPY VISIT LIMIT |
| 0782 | CLAIM/DETAIL DENIED. THE MEMBER'S ANNUAL PHYSICAL THERAPY VISIT LIMIT |
| 0783 | FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR |
| 0784 | PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE |
| 0785 | CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER |
| 0786 | CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER |
| 0788 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER |
| 0789 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8) |
| 0790 | CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER |
| 0791 | CLAIM DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY). |
| 0792 | CLAIM DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD. |
| 0793 | CLAIM DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS. |
| 0794 | CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER MEMBER. |
| 0795 | CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. |
| 0796 | CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. |
| 0797 | THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED |
| 0798 | PROCEDURE CODE XZ299 IS LIMITED TO $150.00 PER CALENDAR MONTH PER MEMBER, PER PROVIDER. |
| 0799 | REVENUE CODE 270 CANNOT EXCEED $2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH. |
| 0800 | CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVICE AS X0076. |
| 0801 | CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0074 OR X0075. |
| 0802 | EVALUATION CODES DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE SAME DATE OF SERVICE AS PROCEDURES 09110/D9110, 00140/D0140 OR 09420/D9420. |
| 0803 | MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271. |
| 0808 | MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPPING DATE OF SERVICE AS DAILY DIALYSIS PROCEDURE CODES. |
| 0809 | DATE PRESCRIBED IS MISSING |
| 0810 | HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATES OF SERVICE AS EVALUATION AND MANAGEMENT PROCEDURE CODES. |
| 0811 | NDC IS MISSING |
| 0812 | ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN BILLING FOR SUTURE OF WOUND. |
| 0813 | QUANTITY DISPENSED IS INVALID. |
| 0814 | MEMBER ID NUMBER IS INVALID. |
| 0815 | CLAIM DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS COMMUNITY RESIDENTIAL SERVICES. |
| 0816 | CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROCEDURES, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROCEDURES TO THE DMS FOR R |
| 0818 | VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES. |
| 0820 | BILLING OR REFERRING KENPAC PROVIDER NUMBER IS MISSING OR IS NOT THE KENPAC PHYSICIAN/CLINIC FOR DATE(S) BILLED. KENPAC REFERRING PROVIDER NUMBER SHOULD BE E |
| 0821 | CLAIM DETAIL DENIED. LIMITATION EXCEEDED, PRIOR AUTHORIZATION REQUIRED. |

| EOB Code | Description |
|---|---|
| 0822 | X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES. |
| 0824 | DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OTHER PROCEDURE CODES IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER. |
| 0825 | DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER. |
| 0826 | PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTAL PROCEDURE CODES FOR THE SAME DATE OF SERVICE. |
| 0827 | THIS PROCEDURE CODE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE CODE 09110/D9110 FOR THE SAME DATE OF SERVICE. |
| 0828 | CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIALTY CODE. |
| 0829 | CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PROVIDED TO KCHIP PHASE III MEMBERS. |
| 0830 | CLAIM DENIED. NO DRG FOUND. |
| 0831 | CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE. |
| 0832 | CLAIM DENIED. DRG CRITERIA NOT MET. |
| 0833 | CLAIM DENIED. DRG INVALID AGE. |
| 0834 | CLAIM DENIED. DRG INVALID SEX. |
| 0835 | CLAIM DENIED. DRG INVALID DISCHARGE STATUS. |
| 0836 | CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS. |
| 0837 | CLAIM DENIED. DRG DENY 469 THROUGH 470. |
| 0838 | PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER |
| 0839 | RESERVED FOR DRG |
| 0840 | PROCEDURE CODE HAS BEEN REBUNDLED. |
| 0841 | BYPASS INDICATOR, GMIS INFORMATIONAL ONLY. |
| 0842 | PROCEDURE CODE IS MUTUALLY EXCLUSIVE. |
| 0843 | PROCEDURE CODE IS INCIDENTAL. |
| 0844 | PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT. |
| 0845 | VISIT IS WITHIN ONE DAY PRE OP RANGE. |
| 0846 | PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE. |
| 0847 | PROCEDURE IS A BILATERAL OR DUPLICATE |
| 0848 | PLEASE PAY SPECIFIED PROCEDURE CODES. |
| 0849 | PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON. |
| 0850 | PROCEDURE CODE IS INVALID FOR PATIENTS AGE. |
| 0851 | PROCEDURE CODE IS INVALID FOR PATIENTS SEX. |
| 0852 | INAPPROPRIATE PROCEDURE CODE FOR MEMBER'S AGE. |
| 0853 | PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS |
| 0854 | MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS. |
| 0855 | KYCONV-DESCRIPTION NOT FOUND |
| 0856 | PROCEDURE IS INVALID FOR THE MEMBER'S GENDER. |
| 0857 | PROCEDURE NOT INDICATED FOR A FEMALE |
| 0858 | CLAIM DENIED. COSMETIC PROCEDURE. |
| 0859 | CLAIM DENIED. DUPLICATE PROCEDURE. |
| 0860 | CLAIM DENIED. EXPERMENTAL PROCEDURE. |
| 0861 | CLAIM DENIED. OBSOLETE PROCEDURE. |
| 0863 | PROCEDURE CODES DOES NOT REQUIRE AN ASSTANT SURGEON |
| 0864 | PROCEDURE CODE IS INVALID FOR LOCATION. |
| 0865 | PROCEDURE CODE NEEDS TO BE REPLACED. |
| 0866 | PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED. |
| 0867 | PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED. |
| 0868 | CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS LIMITED TOONE PER FOUR YEARS. |
| 0871 | CLAIM/DETAIL DENIED. HEARING AID FITTING/CHECKING LIMITED TO 6 PER CALENDAR YEAR. |
| 0872 | CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO $1200.00 PER EAR, PER 36 MONTHS |
| 0873 | CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $400.00 PER CALENDAR YEAR HAS |
| 0874 | CLAIM/DETAIL DENIED. EYEWARE LIMITATION OF $200.00 PER CALENDAR YEAR HAS |
| 0875 | CLAIM/DETAIL DENIED. PROSTHETIC DEVICE LIMITATION OF $1500.00 PER |
| 0876 | CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO $800.00 PER EAR, PER |
| 0877 | CLAIM/DETAIL DENIED. CHILDREN'S DENTAL PROPHYLAXIS AND FLOURIDE |
| 0878 | CLAIM/DETAIL DENIED. THE 12-MONTH LIMIT FOR DENTAL PROPHYLAXIS |
| 0879 | PROCEDURE REQUIRES DOCUMENTATION |
| 0880 | CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14 |
| 0881 | CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14. |
| 0882 | CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID |
| 0883 | CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID. |
| 0884 | CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL |
| 0885 | CLAIM DENIED. PROCEDURE IS CONSIDERED OBSOLETE. |
| 0886 | INAPPROPRIATE PROCEDURE CODE BILLED. |
| 0888 | VISIT IS WITHIN THE POST-OP RANGE. |
| 0889 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE. |
| 0890 | CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES. |
| 0891 | CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED SUBSTANCE ABUSE DIAGNOSIS CODES. |
| 0893 | UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT. |
| 0894 | DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET. |
| 0896 | CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT. |
| 0897 | CLAIM DENIED TO PROVIDER NUMBER 99999997 FOR REBATCH OR RETURN REASONS. |
| 0898 | TOO MANY CLAIMS IN A CYCLE. |
| 0899 | DENIED PER PROVIDER REQUEST. |
| 0900 | THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESUBMIT YOUR CLAIM. |
| 0901 | DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM. |
| 0902 | CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/ MAXIMUM QUANTITIES. |
| 0903 | CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID. |
| 0904 | CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE. |
| 0905 | CLAIM CREDIT QUANTITY MUST BE EQUAL TO OR LOWER THAN ORIGINAL CLAIM QUANTITY, PLEASE RESUBMIT. |
| 0906 | PRESCRIBING PROVIDER'S LICENSE NUMBER MISSING INVALID OR NOT ON KY MEDICAID FILE. |
| 0907 | CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE. |

| EOB Code | Description |
|---|---|
| 0908 | CLAIM\DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE. |
| 0909 | CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO. |
| 0910 | CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO. |
| 0911 | MODIFIER INVALID FOR PROCEDURE CODE BILLED. |
| 0912 | CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED. |
| 0913 | CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED. |
| 0914 | CLAIM DENIED. HEADER COVERED DAYS GREATER THAN THE 14 DAY MAXIMUM ALLOWED. |
| 0915 | CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT. |
| 0916 | EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS MEMBER. |
| 0917 | CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBER'S AGE. |
| 0918 | CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE. |
| 0919 | DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBER'S 21ST BIRTHDAY. |
| 0920 | CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES. |
| 0921 | CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE. |
| 0922 | THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM A PAID MEDICARE EOMB. |
| 0923 | CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENT'S ACCOUNT NUMBER FIELD ON THE CLAIM. |
| 0924 | CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBER'S 6THBIRTHDAY MUST BE SPLIT BILLED. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOURP |
| 0925 | CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES. |
| 0926 | CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS VENIPUNCTURE AND ARTERIAL PUNCTURE. |
| 0927 | CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED. |
| 0928 | DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED. |
| 0929 | CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE. |
| 0930 | CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE. |
| 0931 | CLAIM DENIED. COMPOUND CODE MISSING OR INVALID. |
| 0932 | CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR |
| 0933 | CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID. |
| 0934 | CLAIM DENIED DUE TO TRANSITION TO NEW SYSTEM. PLEASE RESUBMIT CLAIM. |
| 0935 | DRUG INCOMPATABILITY ALERT. |
| 0936 | CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE. |
| 0937 | CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD. |
| 0938 | CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED |
| 0939 | CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER CALENDAR YEAR. |
| 0941 | CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE. |
| 0942 | CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE. |
| 0943 | CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2 |
| 0944 | LOW DOSE ALERT. |
| 0945 | HIGH DOSE ALERT. |
| 0946 | LATE REFILL. |
| 0947 | MINIMUM DURATION ALERT. |
| 0948 | MAXIMUM DURATION ALERT. |
| 0949 | DRUG ALLERGY ALERT. |
| 0950 | CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY MEMBERS. |
| 0951 | THIS SERVICE IS NOT COVERED BY MEDICAID. |
| 0952 | REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT. |
| 0953 | CLAIM DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED PER MODIFIER. |
| 0954 | CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID. |
| 0955 | CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT. |
| 0956 | THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE. |
| 0957 | CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCEDURE CODE |
| 0958 | EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 070193, A FIVE- DIGIT MODIFIER MUST BE BILLED ON COMMUNITY MENTAL HEALTH CENTER CLAIMS. |
| 0959 | PRIOR ADVERSE DRUG REACTION. |
| 0960 | THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED TO NON-COVERED. |
| 0961 | THIS REV CODE IS NOT PAYABLE WHEN BILLED W/ ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE 240. CHARGES MOVED TO NON-COVERED. |
| 0962 | PREGNANCY ALERT. |
| 0963 | DRUG/GENDER ALERT. |
| 0964 | CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS THIS AGE. |
| 0965 | CLAIM DENIED. CHILDREN'S TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 20. |
| 0966 | CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS UNDER AGE 18. |
| 0967 | CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY. |
| 0968 | CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY. |
| 0969 | THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD. |
| 0970 | THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE. |
| 0971 | LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID. |
| 0972 | CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN, AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY. |
| 0973 | PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DATE OF SERVICE. |
| 0974 | DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PROCEDURE. |
| 0975 | UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PROCEDURE. |
| 0976 | PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY. |
| 0977 | TYPE OF BILL INVALID FOR PROVIDER TYPE. |
| 0978 | CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM. |
| 0979 | CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTER 7/1/95 MUST BE SUBMITTED ON PAPER. |
| 0980 | COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO THE MEMBER'S ANNUAL OUT-OF-POCKET USED AMOUNT BUT WAS NOT DEDUCTED FROM YOUR CLAIM. |
| 0981 | CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR CERTAIN PROCEDURE CODES, FOR DATES OF SERVICE AFTER 11/30/02. PLEASE VERIFY OUR |
| 0982 | CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 FOR ADMINISTRATION TO INDICATE VACCINE OBTAINED FROM PRIVATE SOURCE. |
| 0984 | CLAIM DOES NOT INDICATE THAT COINSURANCE, DEDUCTIBLE, OR COPAY AMOUNTS ARE DUE. |
| 0985 | DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE. |

| EOB Code | Description |
|---|---|
| 0986 | DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE. |
| 0987 | DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP. |
| 0988 | HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS. |
| 0989 | CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP. |
| 0990 | DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBER'S THIRD BIRTHDAY. |
| 0991 | KYCONV-DESCRIPTION NOT FOUND |
| 0992 | DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13. |
| 0993 | CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE. |
| 0994 | CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE AS ADDITIONAL PASSENGER PROCEDURE CODES. |
| 0996 | NUMBER OF STUDENTS IN GROUP MISSING OR INVALID. |
| 0997 | CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN ADJUSTMENT WITH CORRECTED VALID PRESCRIBER LICENSE NUMBER. |
| 0998 | CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED. |
| 0999 | PENDING FOR REVIEW. |
| 1000 | INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE. |
| 1001 | INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER). |
| 1002 | COB - PAYER |
| 1003 | INDIVIDUAL/BILLING PROVIDER (GROUP)/NPI NUMBER(S) NOT ENROLLED AT SERVICE LOCATION FOR PROGRAM BILLED (HEADER). |
| 1004 | CLAIM SUBMITTED WITH INVALID OR NO ICD VERSION. |
| 1005 | CLAIM DENIED. CLAIM DOS CANNOT SPAN ICD10 EFFECTIVE DATE. |
| 1006 | FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED |
| 1007 | REVENUE CODES 681, 682, AND 683 684 CAN BE BILLED ONLY BY TRAUMA CENTERS/HOSPITALS DESIGNATED AS SUCH BY THE STATE OR LICENSING. |
| 1008 | REVENUE CODE BILLED DOES NOT MATCH THE DESIGNATED LEVEL OF TRAUMA FOR HOSPITALPROVIDER. |
| 1009 | REQUIRED DOCUMENTATION AND/OR INVOICE IS MISSING OR DOES NOT SUPPORT TRAUMA TEAM ACTIVATION/RESPONSE. |
| 1010 | RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP. |
| 1011 | INTERNAL ERROR |
| 1015 | CLAIM DENIED. ONE OF THE PROVIDERS SUBMITTED ON YOUR CLAIM IS NOT ENROLLED WITH KY MEDICAID. PLEASE GO TO KY MPPA TO ENROLL THE PROVIDER, HTTPS://MEDICAIDSY |
| 1016 | NON-PARTICIPATING MANUFACTURER |
| 1018 | NO PRICING SEGMENT FOR LEVEL OF CARE |
| 1037 | FACILITY PROVIDER I.D. NOT ON FILE |
| 1042 | RENDERING PROVIDER IS NOT ELIGIBLE. |
| 1043 | REFERRING PROVIDER IS NOT ELIGIBLE. |
| 1046 | FACILITY PROVIDER IS NOT ELIGIBLE. |
| 1047 | BILLING PROVIDER IS NOT ELIGIBLE. |
| 1049 | BILLING PROVIDER IS SUSPENDED OR TERMINATED. |
| 1052 | TAXONOMY CODE INVALID FOR RENDERING PROVIDER |
| 1053 | TAXONOMY CODE INVALID FOR PERFORMING PROVIDER |
| 1054 | TAXONOMY CODE INVALID FOR BILLING PROVIDER |
| 1055 | DTL REFERRING PROV NOT ON FILE |
| 1058 | NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM |
| 1059 | THIS SERVICE IS NOT A VALID ENCOUNTER UNDER THE SOONERCARE CHOICE PROGRAM UNLESS IT IS BILLED BY THE MEMBER'S PCP/CM. |
| 1060 | NO RENDERING PROVIDER FOR CROSSOVER CLAIM |
| 1061 | NO FACILITY PROVIDER FOR CROSSOVER CLAIM |
| 1073 | CLAIM/SERVICE DENIED. THE BILLING PROVIDER SUBMITTED A CROSSOVER CLAIM THAT WASNOT SUBMITTED FROM `COBA? (MEDICARE). |
| 1106 | THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE SERVICE PERFORMED. THE BILLED AMOUNT FOR THIS PROCEDURE IS THE SUM OF THE TOTA |
| 1112 | DETAIL DENIED. THE PROCEDURE BILLED HAS BEEN REBUNDLED TO A GLOBAL CPT-4 CODE THAT MORE ACCURATELY REFLECTS THE COMPREHENSIVE NATURE OF THE SERVICE THAT WAS |
| 1117 | CHRIS TEST |
| 1118 | THIS DRUG NOT COVERED BY MEDICARE PART D |
| 1121 | FOR QMB ONLY MEMBERS, THIS SERVICE IS NOT PAYABLE. FOR QDWI, QI1, QI2, AND SLMB MEMBERS, KENTUCKY MEDICAID PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS. |
| 1123 | THIS GLOBAL CPT-4 PROCEDURE CODE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE SERVICE PERFORMED. THE BILLED AMOUNT FOR THIS PROCEDURE IS THAT SUM OF THE TOT |
| 1129 | DETAIL DENIED. PROCEDURE BILLED WAS PERFORMED WITH A PRIMARY PROCEDURE. ACCORDING TO THE NATIONAL CORRECT CODING GUIDE THIS PROCEDURE IS CONSIDERED CONTENT OF |
| 1606 | MISSING OR INVALID PAYER DATE |
| 1643 | INVALID OTHER COVERAGE CODE |
| 1652 | MISSING OR INVALID OTHER PAYER COVERAGE TYPE |
| 1750 | REFERRING OR ORDERING PROVIDER NPI IS REQUIRED FOR THIS SERVICE. |
| 1751 | HEADER REFERRING PROVIDER1 NPI IS NOT ON FILE. |
| 1752 | HEADER REFERRING PROVIDER1 NPI IS NOT VALID FOR THE DATE OF SERVICE. |
| 1753 | HEADER REFERRING PROVIDER1 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE. |
| 1754 | HEADER REFERRING PROVIDER2 NPI IS NOT ON FILE. |
| 1755 | HEADER REFERRING PROVIDER2 NPI IS NOT VALID FOR THE DATE OF SERVICE. |
| 1756 | HEADER REFERRING PROVIDER2 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE. |
| 1757 | DETAIL REFERRING PROVIDER1 NPI IS NOT ON FILE. |
| 1758 | DETAIL REFERRING PROVIDER1 NPI IS NOT VALID FOR THE DATE OF SERVICE. |
| 1759 | DETAIL REFERRING PROVIDER1 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE. |
| 1760 | DETAIL REFERRING PROVIDER2 NPI IS NOT ON FILE. |
| 1761 | DETAIL REFERRING PROVIDER2 NPI IS NOT VALID FOR THE DATE OF SERVICE. |
| 1762 | DETAIL REFERRING PROVIDER2 NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER ID FOR THE DATE OF SERVICE. |
| 1763 | DETAIL ORDERING PROVIDER NPI IS NOT ON FILE. |
| 1764 | DETAIL ORDERING PROVIDER NPI IS NOT VALID FOR THE DATE OF SERVICE. |
| 1765 | DETAIL ORDERING PROVIDER NPI DOES NOT HAVE A MATCHING ORP MEDICAID PROVIDER IDFOR THE DATE OF SERVICE. |
| 1766 | REFERRING PROVIDER1 NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE ONTHIS DENTAL CLAIM. |
| 1767 | CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER1 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM. PLEASE RESUBMIT WITH TAXONOMY. |
| 1768 | REFERRING PROVIDER1 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE. |
| 1769 | REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM. |
| 1770 | REFERRING PROVIDER1 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM. |

| EOB Code | Description |
|---|---|
| 1771 | REFERRING PROVIDER1 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM. |
| 1772 | THE REFERRING PROVIDER1 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL PROVIDER. |
| 1773 | REFERRING PROVIDER2 NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE ONTHIS DENTAL CLAIM. |
| 1774 | CANNOT DETERMINE MEDICAID ID FROM THE NPI. REFERRING PROVIDER2 TAXONOMY IS REQUIRED FOR THIS DENTAL CLAIM. PLEASE RESUBMIT WITH A TAXONOMY. |
| 1775 | REFERRING PROVIDER2 TAXONOMY ON THIS DENTAL CLAIM IS NOT ON FILE. |
| 1776 | REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT FOUND FOR THIS DENTAL CLAIM. |
| 1777 | REFERRING PROVIDER2 NPI/TAXONOMY COMBINATION NOT VALID FOR THE DATE OF SERVICEON THIS DENTAL CLAIM. |
| 1778 | REFERRING PROVIDER2 MEDICAID PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE ON THIS DENTAL CLAIM. |
| 1779 | THE REFERRING PROVIDER2 ON THIS DENTAL CLAIM IS NOT A VALID ORP MEDICAID PROVIDER TYPE OR IS NOT AN INDIVIDUAL PROVIDER. |
| 1780 | ATTENDING PROVIDER NPI IS REQUIRED. |
| 1781 | ATTENDING PROVIDER NPI IS NOT ON FILE OR NOT VALID FOR THE DATE OF SERVICE. |
| 1782 | ATTENDING PROVIDER TAXONOMY IS NOT ON FILE. |
| 1783 | CANNOT DETERMINE ATTENDING MEDICAID ID FROM THE NPI. ATTENDING PROVIDER TAXONOMY IS REQUIRED. PLEASE RESUBMIT WITH ATTENDING PROVIDER TAXONOMY. |
| 1784 | ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT FOUND. |
| 1785 | ATTENDING PROVIDER NPI/TAXONOMY COMBINATION NOT ELIGIBLE FOR THE HEADER FROM DATE OF SERVICE. |
| 1786 | ATTENDING PROVIDER MEDICAID ID IS NOT ELIGIBLE FOR THE DATE OF SERVICE. |
| 1787 | ATTENDING PROVIDER IS NOT A VALID ORP MEDICAID PROVIDER TYPE. |
| 1788 | ATTENDING PROVIDER NPI DOES NOT HAVE A MATCHING ORP PROVIDER FOR THE DATE OF SERVICE. |
| 1789 | PRESCRIBING PROVIDER NPI IS NOT ON FILE OR DOES NOT HAVE A MATCHING ELIGIBLE PRESCRIBING PROVIDER FOR THE DATE OF SERVICE. |
| 1800 | BILLING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KYHEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1801 | RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1802 | REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1803 | SERVICE FACILITY NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1804 | DETAIL RENDERING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1805 | DETAIL REFERRING NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITHYOUR KY HEALTH CHOICES PROVIDER IDENTIFICATION NUMBER |
| 1806 | BILLING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1807 | RENDERING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1808 | REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1809 | SERVICE FACILITY ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1811 | DETAIL RENDERING PROVIDER ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OFSERVICE |
| 1812 | DETAIL REFERRING ATYPICAL PROVIDER NPI NOT ELIGIBLE FOR CLAIM DATE OF SERVICE |
| 1814 | IF THE BILLING PROVIDER SUBMITS ANY OTHER SECONDARY NUMBER, POST THE EDIT. |
| 1815 | RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1816 | REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1817 | KENTUCKY FACILITY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI MUST BE SUBMITTED AFTER MAY 22, 2008. |
| 1818 | OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1819 | DETAIL RENDERING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1820 | DETAIL REFERRING PROVIDER SUBMITTED OTHER SECONDARY NUMBER ON CLAIM |
| 1821 | DETAIL OTHER PROVIDER 2 SUBMITTED OTHER SECONDARY NUMBER ON CLAIM. |
| 1822 | RENDERING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1823 | REFERRING PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1824 | SERVICE FACILITY PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1825 | OTHER PROVIDER 2 NPI NOT ON KY HEALTH CHOICES FILE |
| 1826 | DETAIL RENDERING PROVIDER NPI NOT ON FILE |
| 1827 | DETAIL REFERRING PROVIDER NPI NOT ON FILE |
| 1828 | DETAIL OTHER PROVIDER 2 NPI NOT ON FILE |
| 1829 | RENDERING PROVIDER NPI NOT ON FILE |
| 1830 | REFERRING PROVIDER NPI NOT ON FILE |
| 1831 | SERVICE FACILITY PROVIDER NOT ON FILE |
| 1832 | OTHER PROVIDER 2 NPI NOT ON FILE |
| 1833 | DETAIL RENDERING PROVIDER NPI NOT ON FILE |
| 1834 | DETAIL REFERRING PROVIDER NPI NOT ON FILE |
| 1835 | DETAIL OTHER PROVIDER 2 PROVIDER NPI NOT ON FILE |
| 1836 | BILLING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1837 | RENDERING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1838 | REFERRING NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1839 | FACILITY NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1840 | OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1841 | RENDERING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1842 | REFERRING NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1843 | OTHER PROVIDER 2 NPI ONLY SUBMITTED ON CLAIM AT DETAIL - NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1844 | KY HEALTH CHOICES BILLING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED |
| 1845 | KY HEALTH CHOICES RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED |
| 1846 | KY HEALTH CHOICES REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIMS DATES OF SERVICE SUBMITTED |
| 1847 | KY HEALTH CHOICES SERVICE FACILITY MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED |
| 1848 | KY HEALTH CHOICES OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED |
| 1849 | KY HEALTH CHOICES DETAIL RENDERING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED |
| 1850 | KY HEALTH CHOICES DETAIL REFERRING MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATESOF SERVICE SUBMITTED |
| 1851 | KY HEALTH CHOICES DETAIL OTHER PROVIDER 2 MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED |
| 1852 | SUBMITTED BILLING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALIDTAXONOMY CODES AT WWW.WPC-EDI.COM |
| 1853 | SUBMITTED RENDERING TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-EDI.COM |
| 1854 | WARNING - SUBMITTED REFERRING TAXONOMY CODE AT HEADER IS NOT VALID CODE - CHECKFOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM |
| 1856 | SUBMITTED DETAIL RENDERING TAXONOMY CODE IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODE AT WWW.WPC-EDI.COM |
| 1857 | BILLING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE |
| 1858 | RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1859 | REFERRING TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1861 | DETAIL RENDERING TAXONOMY CODE FOR PROVIDER NOT VALID FOR DATE OF SERVICE |
| 1862 | BILLING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE. |
| 1863 | HEADER RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE. |

| EOB Code | Description |
|---|---|
| 1864 | REFERRING PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1866 | DETAIL RENDERING PROVIDER TAXONOMY CODE NOT VALID FOR PROVIDER FOR DATE OF SERVICE. |
| 1870 | BILLING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED |
| 1871 | REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED |
| 1872 | RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED |
| 1873 | SERVICE FACILITY PROV SUBMITTED NPI AND LEGACY NUM- LEGACY NUM NOT PROCESSED |
| 1874 | OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED |
| 1875 | RENDERING PROVIDER SUBMITTED NPI AND LEGACY NUMBER. LEGACY NUMBER NOT PROCESSED |
| 1876 | REFERRING PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED |
| 1877 | OTHER PROVIDER 2 PROVIDER SUBMITTED NPI AND LEGACY NUMBER ? LEGACY NUMBER NOT PROCESSED |
| 1878 | PRESCRIBER'S NPI IS INVALID |
| 1879 | PRESCRIBER'S NPI IS MISSING |
| 1880 | PRESCRIBER'S NPI IS NOT ON FILE |
| 1881 | BILLING PROVIDER TAXONOMY IS MISSING. |
| 1882 | RENDERING PROVIDER TAXONOMY IS MISSING. |
| 1900 | NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION NUMBER |
| 1901 | NPI NOT REQUIRED FOR PROVIDER TYPE, PLEASE RESUBMIT CLAIM WITH YOUR KY HEALTHCHOICES PROVIDER IDENTIFICATION NUMBER |
| 1902 | KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED |
| 1903 | KY HEALTH CHOICES MEDICAID NUMBER NOT ELIGIBLE FOR CLAIM DATES OF SERVICE SUBMITTED |
| 1904 | WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM SUBMITTED DATES OF SERVICE |
| 1905 | WARNING - NPI AND KY HEALTH CHOICES MEDICAID NUMBER SUBMITTED ON CLAIM - NPI ISNOT ELIGIBLE FOR THE CLAIM SUBMITTED DATES OF SERVICE |
| 1906 | WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATHEADER NOT ON FILE - PLEASE VERIFY YOUR NPI NUMBER WITH KY HEALTH CHOICES |
| 1907 | WARNING - NPI NOT REGISTERED WITH KY HEALTH CHOICES - NPI SUBMITTED ON CLAIM ATDETAIL NOT ON FILE - PLEASE VERIFY YOUR NPI NUMBER WITH KY HEALTH CHOICES |
| 1908 | BILLING NPI ONLY SUBMITTED ON CLAIM. NPI IS NOT ON FILE |
| 1909 | TAXONOMY IS NOT VALID FOR FACILITY PROVIDER |
| 1910 | NPI ONLY SUBMITTED ON CLAIM AT HEADER ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1911 | NPI ONLY SUBMITTED ON CLAIM AT DETAIL ? NPI IS NOT ELIGIBLE FOR THE DATES OF SERVICE SUBMITTED ON CLAIM |
| 1912 | WARNING - SUBMITTED TAXONOMY CODE AT HEADER IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM |
| 1913 | WARNING - SUBMITTED TAXONOMY CODE AT DETAIL IS NOT A VALID CODE - CHECK FOR VALID TAXONOMY CODES AT WWW.WPC-EDI.COM |
| 1914 | PROVIDER NPI NOT ON KY HEALTH CHOICES FILE |
| 1915 | PROVIDER NPI NOT ON FILE |
| 1916 | PROVIDER NPI NOT ON FILE |
| 1917 | PROVIDER NPI NOT ON FILE - DETAIL |
| 1918 | WARNING - BILLING PROVIDER 5 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE VERIFY YOUR 5 DIGIT ZIP CODE WITH KY HEALTH CHOI |
| 1919 | WARNING - BILLING PROVIDER 5 + 4 DIGIT ZIP CODE DOES NOT MATCH WHAT IS REGISTERED WITH KY HEALTH CHOICES - PLEASE VERIFY YOUR 5 + 4 DIGIT ZIP CODE WITH KY HEA |
| 1920 | WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM. A VALID NPI ONLY MUST BE SUBMITTED AFTER MAY 22, 2008 |
| 1921 | WARNING - KENTUCKY MEDICAID NUMBER SUBMITTED ON CLAIM AT DETAIL - NPI ONLY MUSTBE SUBMITTED AFTER MAY 22, 2008 |
| 1922 | MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 DIGITZIP CODE SUBMITTED ON CLAIM DOES NOT MATCH PROVIDER FILE 5 DIGIT ZIP CODE |
| 1923 | MULTIPLE KY MEDICAID MATCHES FOUND FOR NPI SUBMITTED - SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON CLAIM DOES NOT MATCH PROVIDER FILE 5 + 4 DIGIT ZIP |
| 1924 | TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1925 | TAXONOMY CODE FOR PROVIDER NOT VALID FOR CLAIM DATE OF SERVICE |
| 1926 | PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1927 | PROVIDER TAXONOMY CODE MIS/MATCH FOR CLAIM DATE OF SERVICE |
| 1936 | INVALID BILLING PROVIDER OVERRIDE SPECIFIED |
| 1937 | INVALID PERFORMING PROVIDER OVERRIDE SPECIFIED |
| 1938 | INVALID REFERRING PROVIDER OVERRIDE SPECIFIED |
| 1939 | INVALID FACILITY PROVIDER OVERRIDE SPECIFIED |
| 1940 | INVALID RENDERING PROVIDER OVERRIDE SPECIFIED |
| 1941 | INVALID OTHER PROVIDER 2 OVERRIDE SPECIFIED |
| 1942 | INVALID DTL OTHER PROVIDER 2 OVERRIDE SPECIFIED |
| 1943 | INVALID DTL PERFORMING PROVIDER OVERRIDE SPECIFIED |
| 1944 | INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED |
| 1945 | MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER |
| 1946 | MULTIPLE SERVICE LOCATIONS FOR PERFORMING PROVIDER |
| 1947 | MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER |
| 1948 | MULTIPLE SERVICE LOCATIONS FOR FACILITY PROVIDER |
| 1949 | MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER |
| 1950 | PROCEDURE INCLUDED IN BUNDLED RATE |
| 1951 | HCPC IS REQUIRED |
| 1952 | MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER |
| 1953 | MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER |
| 1955 | CLAIM/SERVICE DENIED. THE BILLING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE BILLING PROVIDER. |
| 1956 | CLAIM/SERVICE DENIED. THE REFERRING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOTBE USED TO UNIQUELY IDENTIFY THE REFERRING PROVIDER. |
| 1957 | CLAIM/SERVICE DENIED. THE FACILITY PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE FACILITY PROVIDER. |
| 1958 | CLAIM/SERVICE DENIED. THE OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BEUSED TO UNIQUELY IDENTIFY THE OTHER PROVIDER. |
| 1959 | CLAIM/SERVICE DENIED. THE PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PERFORMING PROVIDER. |
| 1960 | CLAIM/SERVICE DENIED. THE DETAIL REFERRING PROVIDER NPI SUBMITTED ON THE CLAIMCANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL REFERRING PROVIDER. |
| 1961 | CLAIM/SERVICE DENIED. THE DETAIL OTHER PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL OTHER PROVIDER. |
| 1962 | CLAIM/SERVICE DENIED. THE DETAIL PERFORMING PROVIDER NPI SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE DETAIL PERFORMING PROVIDER. |
| 1963 | CLAIM/SERVICE DENIED. THE KENPAC PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CARE PHYSICIAN FOR THE MEMBER ON THE CLAIM. |
| 1964 | THE LOCK IN PROVIDER NPI SUBMITTED ON THE CLAIM DOES NOT MATCH THE PRIMARY CAREPHYSICIAN FOR THE MEMBER ON THE CLAIM. |
| 1965 | CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH THE NPI THAT CORRESPONDS TO YOUR KY MEDICAID PROV NUMBER. IF YOU HAVE REGISTERED ONE NPI FOR MULTIPLE KY PROV TYPES |
| 1966 | THE PROVIDER NPI AND TAXONOMY SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELYIDENTIFY THE PROVIDER |

| EOB Code | Description |
|---|---|
| 1967 | THE PROVIDER NPI AND SERVICE FACILITY 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER |
| 1968 | THE PROVIDER NPI AND SERVICE FACILITY 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER |
| 1969 | THE PROVIDER NPI AND BILLING PROVIDER 5 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER |
| 1970 | THE PROVIDER NPI AND BILLING PROVIDER 5 + 4 DIGIT ZIP CODE SUBMITTED ON THE CLAIM CANNOT BE USED TO UNIQUELY IDENTIFY THE PROVIDER |
| 1971 | THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI |
| 1972 | THE KY MEDICAID NUMBER SUBMITTED ON THE CLAIM DOES NOT MATCH THE CROSS-WALKED KY MEDICAID NUMBER FROM THE NPI |
| 1995 | MMIS FACILITY PROVIDER ID NOT ENROLLED |
| 1996 | THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM. |
| 1997 | THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICAID SYSTEM. PLEASE BILL FUTURE CLAIMS WITH THE PROVIDER NUMBER ASSIGNED DURING |
| 1999 | BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT |
| 2000 | ERROR DISPOSITION SETUP IS INVALID |
| 2001 | MEMBER ID NUMBER NOT ON FILE. |
| 2002 | MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE. |
| 2003 | MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE. |
| 2004 | PROCEDURE INCLUDED IN COMBINED PROCEDURE |
| 2005 | PRESCRIPTION LIMIT EXCEEDED FOR THIS MONTH |
| 2006 | RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA |
| 2007 | PA NOT AUTHORIZED FOR DRUG THERCLASS 46 & 47 |
| 2008 | EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE |
| 2009 | MEMBER INELIGIBLE ON DATE OF SERVICE. |
| 2010 | MULTIPLE ACTIVE PREVIOUS ID'S FOUND FOR MEMBER. |
| 2011 | MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE |
| 2012 | MAXIMUM CRITICAL CARE VISITS EXCEEDED |
| 2013 | EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE |
| 2014 | EXCEEDS MONTHLY CLINIC VISIT LIMITS |
| 2015 | SCHOOL BASED YEARLY LIMIT EXCEEDED |
| 2016 | LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR |
| 2017 | LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED |
| 2018 | DIABETIC SUPPLIES LIMITS EXCEEDED |
| 2019 | 12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED |
| 2020 | YEARLY LIMIT FOR EYE GLASSES EXCEEDED |
| 2021 | 12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED |
| 2022 | A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE |
| 2023 | DEALER LIMITS EXCEEDED |
| 2024 | OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE |
| 2025 | EXCEEDS EARLY INTERVENTION SERVICES LIMITS |
| 2026 | EXCEEDS EPSDT CLINIC LIMITS |
| 2027 | EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS |
| 2028 | EXCEEDS NUTRITIONAL SERVICE FOR YEAR |
| 2029 | EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS |
| 2030 | SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE |
| 2031 | EXCEPTION CODE 031 |
| 2032 | MAXIMUM RENTAL PAYMENT |
| 2033 | HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS |
| 2034 | EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS |
| 2035 | THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED |
| 2036 | ADD'L HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION |
| 2037 | MAXIMUM PAYMENT MADE |
| 2038 | EXCEEDS OXYGEN LIMITS-ONE PER MONTH |
| 2039 | TARGETED ULTRASOUND/AMNIOCENTISIS REVIEW |
| 2040 | THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED |
| 2041 | EXCEPTION CODE 041 |
| 2042 | EXCEEDS ONCE PER MONTH LIMIT |
| 2043 | ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD |
| 2044 | PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV. |
| 2045 | EXCEPTION CODE 045 |
| 2046 | EXCEPTION CODE 046 |
| 2047 | EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT |
| 2048 | CONFLICTING DENTAL SERVICE SAME DAY |
| 2049 | EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH |
| 2050 | EXCEPTION CODE 050 |
| 2051 | EXCEEDS 2 VISIT LIMIT |
| 2052 | NO LTC STAFFING SUBMITTED FOR SERVICE MONTH |
| 2053 | LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER |
| 2054 | PCS INELIGIBLE FOR CATEGORY OF SERVICE |
| 2055 | 2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED |
| 2056 | TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED |
| 2057 | OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED |
| 2058 | YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED |
| 2059 | EXCEPTION CODE 059 |
| 206 | PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT |
| 2060 | EXCEPTION CODE 060 |
| 2061 | EXCEPTION CODE 061 |
| 2062 | EXCEPTION CODE 062 |
| 2063 | EXCEPTION CODE 063 |
| 2064 | EXCEPTION CODE 064 |
| 2065 | EXCEPTION CODE 065 |
| 2066 | EXCEPTION CODE 066 |
| 2067 | EXCEPTION CODE 067 |

| EOB Code | Description |
|---|---|
| 2068 | EXCEPTION CODE 068 |
| 2069 | EXCEPTION CODE 069 |
| 2070 | 2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH |
| 2071 | THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER |
| 2072 | PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS |
| 2073 | EXCEPTION CODE 073 |
| 2074 | PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS |
| 2075 | MEMBER HAS OVERLAPPING PATIENT LIABILITY SEGMENTS. PLEASE CONTACT EDS PROVIDERRELATIONS. |
| 2076 | EXCEEDS YEARLY FAMILY PLANNING EXAM LIMIT |
| 2077 | EXCEPTION CODE 077 |
| 2078 | MEMBER HAS MULTIPLE BENEFIT PLANS FOR THE DATE OF SERVICE RANGE. |
| 2079 | EXCEPTION CODE 079 |
| 2080 | PREVIOUSLY PAID AUDITORY EXAM IN 12 MONTHS |
| 2081 | CHILDRENS DAYS EXCEEDED |
| 2082 | CHILDRENS DAYS EXHAUSTED |
| 2083 | CHILDRENS VISITS EXCEEDED |
| 2084 | CHILDRENS VISITS EXHAUSTED |
| 2085 | CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED |
| 2086 | CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED |
| 2087 | TB DRUG |
| 2088 | EXCEPTION CODE 088 |
| 2089 | EXCEPTION CODE 089 |
| 2090 | PCS - 1500 |
| 2091 | MEMBER HAS MULTIPLE INSTITUTIONAL STATUS CODE. PLEASE CONTACT EDS. |
| 2092 | ALIEN-NO REQUEST FOR AUTHORIZATION RECEIVED |
| 2095 | REVIEW INVALID CARRIER DENIED BATCH |
| 2096 | DDSD HAS DENIAL/SUSPEND EDIT |
| 2098 | HCBW WAIVER HAS DENY/SUSPEND EDIT |
| 2099 | MANUALLY SUSPEND FOR HCA |
| 2101 | ADP WAIVER HAS DENY/SUSP EDIT |
| 2103 | PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE |
| 2104 | INVALID PROVIDER SPECIALTY FOR PROCEDURE |
| 2105 | INVALID DIAGNOSIS FOR PROCEDURE |
| 2106 | MEMBER NAME IS MISSING |
| 2110 | PCS CLAIM - MEMBER NOT PCS ELIGIBLE |
| 2112 | MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS |
| 2114 | OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW |
| 2115 | VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD |
| 2116 | EXCEPTION CODE 116 |
| 2117 | 2 YEAR RESUBMISSION DEADLINE EXCEEDED |
| 2118 | DISCHARGE DATE IS LESS THAN ADMIT DATE |
| 2119 | DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE |
| 2120 | VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD |
| 2121 | CLAIM WAS FILED WITHOUT SERVICING PROVIDER |
| 2122 | INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER |
| 2123 | INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER |
| 2124 | MISSING FIRST DATE OF SERVICE ON CLAIM |
| 2125 | ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG |
| 2126 | FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV |
| 2127 | DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV |
| 2128 | DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV |
| 2129 | MISSING MEMBER ID NUMBER ON CLAIM |
| 2130 | EXCEPTION CODE 130 |
| 2132 | MISSING TOTAL CLAIM CHARGE |
| 2133 | INVALID TOTAL CLAIM CHARGE |
| 2134 | INVALID NET CLAIM CHARGE |
| 2136 | MISSING/INVALID REVENUE CODE |
| 2138 | MISSING/INVALID TYPE OF BILL |
| 2140 | HCPC CODE IS INVALID FOR REVENUE CODE |
| 2141 | TOTAL DAYS LESS THAN COVERED DAYS |
| 2142 | 1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED |
| 2143 | REFILLS EXHAUSTED |
| 2144 | INVALID REFILL INDICATOR VALUE |
| 2146 | HCPC/REVENUE CODE MISSING |
| 2147 | DIAGNOSIS NOT COVERED FOR THIS CLAIM TYPE FOR MEMBER'S BENEFIT PLAN |
| 2148 | PROCEDURE NOT PAYABLE THIS MEMBER |
| 2149 | PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER |
| 2150 | UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS |
| 2151 | MISSING PRESCRIBING PROVIDER NUMBER |
| 2152 | MISSING DRUG CODE |
| 2153 | INVALID DRUG CODE |
| 2154 | MISSING PRESCRIPTION NUMBER |
| 2155 | MISSING DRUG QUANTITY |
| 2156 | MISSING DAYS SUPPLY |
| 2160 | MISSING DIAGNOSIS INDICATOR |
| 2163 | MISSING DIAGNOSIS CODE |
| 2166 | MEMBER ELIGIBILITY PENDING DHS APPROVAL |
| 2167 | INVALID PATIENT STATUS |
| 2168 | INVALID SOURCE OF ADMISSION |
| 2170 | INVALID PLACE OF SERVICE |

| EOB Code | Description |
|---|---|
| 2172 | CLAIM REQUIRES HCPC OR CPT-4 CODE |
| 2173 | ADMIT DATE GREATER THAN FIRST DATE OF SERVICE |
| 2174 | UNITS CANNOT BE LESS THAN DAYS |
| 2175 | SURGICAL PROCEDURE MISSING |
| 2176 | MEMBER NOT ON FILE PAY FROM STATE FUNDS |
| 2178 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2179 | MISSING TOOTH SURFACE |
| 2180 | INVALID TOOTH NUMBER |
| 2181 | INVALID TOOTH SURFACE |
| 2182 | MISSING TOOTH NUMBER |
| 2183 | MISSING UNITS OF SERVICE |
| 2184 | MISSING CHARGE |
| 2185 | LTC MISSING ADMISSION DATE |
| 2186 | INVALID ADMISSION HOUR |
| 2187 | PROCEDURE NOT PAYABLE THIS MEMBER |
| 2189 | PROCEDURE REQUIRES MEDICAL REVIEW |
| 2190 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2191 | ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM |
| 2192 | TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN |
| 2193 | MISSING COVERED DAYS |
| 2194 | AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES |
| 2196 | MISSING ADMISSION DATE |
| 2197 | INVALID INPATIENT REVENUE CODE |
| 2198 | MISSING ATTENDING SURGEON PRESCRIBER NUMBER |
| 2199 | DATE OF SURGERY IS MISSING |
| 2200 | INVALID TYPE OF ADMISSION |
| 2201 | PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM |
| 2202 | SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE |
| 2203 | CLAIMANT SIGNATURE MISSING |
| 2204 | PROVIDER SIGNATURE IS MISSING |
| 2205 | PATIENT NOT CERTIFIED |
| 2206 | PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT |
| 2207 | INVALID LEVEL OF CARE |
| 2208 | INVALID PICKUP LOCATION |
| 2209 | INVALID DESTINATION |
| 2210 | FACILITY PROVIDER SERVICE LOCATION IS MISSING |
| 2213 | PREGNANCY INDICATOR INVALID |
| 2214 | DATE PRESCRIBED IS INVALID |
| 2215 | DATE DISPENSED IS MISSING |
| 2216 | DATE DISPENSED IS INVALID |
| 2222 | MISSING OCCURRENCE DATE |
| 2223 | SERVICE DATES ARE NOT IN SAME MONTH |
| 2224 | INVALID OCCURRENCE DATE |
| 2226 | INVALID CONDITION CODE |
| 2227 | EXCEPTION CODE 227 |
| 2228 | MISSING MEDICARE PAID DATE |
| 2230 | NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE |
| 2231 | ESTIMATED DAYS SUPPLY INVALID |
| 2233 | INSURANCE DENIAL REQUIRED |
| 2234 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2235 | SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE |
| 2236 | SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE |
| 2237 | FACILITY PROVIDER NOT IN VALID FORMAT |
| 2238 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2239 | INVALID OCCURRENCE CODE |
| 2240 | THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING. |
| 2242 | MISSING OCCURRENCE CODE |
| 2244 | INVALID PAY-TO PROVIDER NUMBER |
| 2247 | MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED |
| 2249 | CLAIM HAS NO DETAILS |
| 2250 | MEMBER IS NOT ON ELIGIBILITY FILE |
| 2252 | MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES |
| 2253 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2254 | MEMBER NOT IN MANAGED CARE |
| 2258 | MEMBER IS NOT ON ELIGIBILITY FILE |
| 2259 | DATE BILLED IS INVALID |
| 2260 | SLIMB ONLY/NO MEDICAL ELIGIBILITY |
| 2262 | PROCEDURES NOT PAYABLE TB |
| 2263 | PROCEDURE REQUIRES REVIEW FOR TB MEMBER |
| 2265 | CLAIM HAS THIRD-PARTY PAYMENT |
| 2266 | REFERRING PHYSICIAN NUMBER IS MISSING |
| 2270 | INPATIENT TB NOT COVERED |
| 2271 | MEMBER IS NOT ELIGIBLE ON SERVICE DATE |
| 2272 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN |
| 2273 | SUSPENDED FOR MEMBER REVIEW |
| 2274 | CLAIM INDICATES MEMBER EXPIRED |
| 2276 | NEWBORN-HCA REVIEW |
| 2277 | BILLING PROVIDER IS NOT LISTED AS MEMBER'S LTC PROVIDER. |
| 2278 | DISCHARGE DTE UNEQ TO LTC ELIG |

| EOB Code | Description |
|---|---|
| 2281 | ABORTION NOT COVERED |
| 2282 | PHYSICIAN AUDITOR REVIEW-MODIFIER 24 |
| 2285 | MEMBER NOT ELIGIBLE FOR DATES OF SERVICE |
| 2287 | PROCEDURE NOT PAYABLE VR |
| 2289 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2290 | PROCEDURE IS NOT IN THE SCOPE OF THE PROGRAM |
| 2291 | PROCEDURE REQUIRES MEDICAL REVIEW |
| 2292 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2294 | PROC REQUIRES REVIEW - HCBW |
| 2295 | PROCEDURE REQUIRES PRIOR AUTHORIZATION |
| 2296 | PROVIDER INELIGIBLE FOR PROCEDURES |
| 2297 | PAY TO PROVIDER NOT ELIG FOR PAY-THIS DATE OF SERV |
| 2298 | PROVIDER NUMBER IS A GROUP NUMBER |
| 2300 | NO PROVIDER MASTER RECORD |
| 2302 | PRESCRIBING PROVIDER NOT ON FILE |
| 2303 | PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED. |
| 2304 | PROVIDER INELIGIBLE ON SERVICE DATE |
| 2305 | REVIEW CLAIMS FOR THIS PROVIDER |
| 2306 | PAY TO PROVIDER IS SUSPENDED |
| 2307 | BILLING OUT OF CLIA CERTIFICATE TYPE |
| 2308 | NO PAY-TO PROVIDER RECORD |
| 2309 | REVIEW CLAIM FOR PAY-TO- PROVIDER |
| 2310 | ANESTHESIA MODIFIER IS INVALID OR MISSING |
| 2311 | SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP |
| 2312 | PAY-TO PROVIDER NOT ENROLLED |
| 2313 | DIAGNOSIS CODE MISSING/NOT ON FILE |
| 2314 | SURGICAL PROCEDURE CODE NOT FOUND |
| 2315 | ICD 9 AND ICD 10 QUALIFIERS NOT ALLOWED ON THE SAME CLAIM. |
| 2316 | ATTACHMENT CONTROL NUMBER MISSING |
| 2317 | INVALID/MISSING MODIFIER FOR THIS PROCEDURE |
| 2318 | PROCEDURE REQUIRES MANUAL PRICING |
| 2319 | DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED |
| 2321 | PROCEDURE CODE IS NO LONGER VALID |
| 2322 | DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE |
| 2323 | INVALID MEMBER AGE FOR THIS DIAGNOSIS |
| 2324 | INVALID MEMBER SEX FOR THIS DIAGNOSIS |
| 2326 | INVALID TOOTH NUMBER FOR THIS PROCEDURE |
| 2327 | PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION |
| 2328 | PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE |
| 2329 | INVALID MEMBER SEX FOR THIS PROCEDURE |
| 2331 | THIS DRUG NOT COVERED FOR THE MEMBER |
| 2332 | INVALID PROVIDER TYPE FOR THIS PROCEDURE |
| 2335 | LTC MEMBER - NONCOMP DRUG |
| 2336 | REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS |
| 2337 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2338 | LTC DRUG ONLY |
| 2341 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2342 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2345 | ATTENDING PROVIDER NOT FOUND |
| 2346 | REFERRING PROVIDER NOT FOUND |
| 2347 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2348 | THIS DIAGNOSIS REQUIRES MEDICAL REVIEW |
| 2349 | MEMBER REQUIRES A PROGRAM CODE |
| 235 | PROCEDURE CODE NOT IN VALID FORMAT |
| 2350 | THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT. |
| 2351 | SUBMITTED TO ALLOWED EXCEEDS PERCENT |
| 2352 | ALLOWED TO SUBMITTED EXCEEDS PERCENT |
| 2354 | THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE |
| 2356 | NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED |
| 2357 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2358 | INACTIVE DRUG |
| 2359 | THIS DRUG REQUIRES PRIOR AUTHORIZATION |
| 2360 | THIS NATIONAL DRUG CODE IS NOT ON FILE |
| 2361 | PROCEDURE CODE IS MISSING/NOT ON FILE |
| 2362 | MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM |
| 2366 | THIS DIAGNOSIS REQUIRES REVIEW |
| 2369 | MEDICARE COINSURANCE GREATER THAN MEDICARE PAID |
| 2371 | THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION |
| 2372 | ITEM NOT PAYABLE IN LONG TERM CARE FACILITY |
| 2374 | MISSING PRESCRIBER PROVIDER ON DEALER CLAIM |
| 2375 | SERVICE NOT ON EXPLANTION OF MEDICARE PAYMENTS |
| 2377 | MEMBER IS INELIGIBLE FOR THIS DRUG |
| 2379 | PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW |
| 2383 | MULTIPLE SURGERY REQUIRES REVIEW |
| 2385 | REVENUE CODE NOT ON FILE |
| 2388 | IMPROPER MODIFIER FOR CRNA |
| 2389 | THIS MODIFIER IS ALLOWED FOR CRNA ONLY |
| 2390 | MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE |
| 2391 | INVALID USE OF E DIAGNOSIS CODE |
| 2394 | VERIFY PCS TPL |

| EOB Code | Description |
|---|---|
| 2396 | LOC ON CLAIM CONFLICTS WITH LOC ON FILE |
| 2397 | INVALID LTC TERMINATION CODE |
| 2399 | REFERRING PROVIDER I.D. # IS NOT IN A VALID FORMAT |
| 2400 | INVALID LOC DAYS |
| 2401 | INVALID LEAVE DAYS |
| 2402 | INVALID TYPE OF LEAVE |
| 2406 | LTC LEAVE DATES CONFLICT |
| 2407 | THERAPEUTIC DAYS GT THAN 14 |
| 2410 | PA IS REQUIRED |
| 2411 | THERAPEUTIC DAYS USED EXCEEDS AUTHORIZATION |
| 2412 | DETAIL DENIED.  ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL. |
| 2413 | LTC BLOCK 13:TOTAL DAYS DO NOT EQUAL FROM/TO DAYS |
| 2414 | WAIVER SERVICES LONG TERM CARE CONFLICT |
| 2416 | AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE |
| 2417 | REVIEW AMBULANCE NON ROUTINE DESTINATION |
| 2419 | MEMBER IS ELIGIBLE FOR PACE. |
| 2420 | THIS DRUG NOT PAYABLE FOR MEMBER AGE |
| 2421 | THIS DRUG NOT PAYABLE FOR MEMBER SEX |
| 2425 | THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE |
| 2430 | LTC INVALID MEMBER ID NUMBER |
| 2431 | LTC NO PROV MASTER RECORD |
| 2433 | LTC MISSING PROVIDER NUMBER |
| 2434 | LTC INVALID PROV NUM CK-DIGIT |
| 2435 | LTC FIRST DATE OF SERVICE MISSING |
| 2436 | LTC FILING DEADLINE EXCEEDED |
| 2437 | LTC FIRST DATE GREATER LAST DATE |
| 2438 | LTC RECHECK SERVICE DATE |
| 2439 | LTC MISS MEMBER ID NUMBER |
| 2443 | LTC MEMBER NOT ON ELIG FILE |
| 2444 | LTC MEMBER INELIGIBLE ON SERVICE DATES |
| 2445 | LTC MEMBER NOT ELIGIBLE ON SERVICE DATES |
| 2446 | LTC MEMBER SUSPEND FOR REVIEW |
| 2447 | LTC PROV IS SUSPENDED |
| 2448 | LTC PROVIDER IS INELIGIBLE ON SERVICE DATES |
| 2449 | LTC REVIEW CLAIM FOR PROV |
| 2450 | INVALID QUADRANT |
| 2451 | LTC INV PROVIDER NUMBER |
| 2452 | RENDERING PROVIDER SERVICE LOCATION IS MISSING |
| 2453 | INVALID DIAGNOSIS TREATMENT INDICATOR |
| 2454 | INVALID ASSIGNMENT CODE |
| 2456 | INVALID PROCEDURE TYPE |
| 2458 | ALIEN MEMBER ON REVIEW |
| 2459 | REVENUE CODES OP401 & OP403 NEED HCPC CODE |
| 2460 | CANNOT DETERMINE THE INPATIENT LEVEL OF CARE |
| 2461 | OCCURENCE CODE SPAN MISSING/INVALID |
| 2462 | INVALID/MISSING SPAN DATE |
| 2463 | SPAN THRU DATE LESS THAN SPAN FROM DATE |
| 2464 | SPAN DATE CONFLICT WITH DATES OF SERVICE SHOWN |
| 2465 | SPAN DATES OVERLAP |
| 2466 | SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS |
| 2468 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2469 | LTC MEMBER NAME/ID MISMATCH |
| 2470 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2471 | NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED |
| 2472 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2473 | NAME ON CLAIM MUST MATCH DHS IDENTIFICATION |
| 2474 | DATE DISPENSED AFTER BILLING DATE |
| 2475 | DATE DISPENSED AFTER ICN DATE |
| 2476 | MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID |
| 2477 | THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT |
| 2478 | PCS MISSING SUBMITTED CHARGE |
| 2479 | CLIA OUT OF DATE |
| 2485 | DATE DISPENSED EARLIER THAN DATE PRESCRIBED |
| 2486 | INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION |
| 2487 | PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE |
| 2488 | ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE |
| 2489 | NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2490 | INPATIENT SERVICES ARE NOT COVERED FOR THIS MEMBER |
| 2491 | DRUG NOT APPROVED |
| 2492 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2493 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2494 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2495 | NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2496 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2497 | NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE |
| 2498 | NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE |
| 2499 | TPL PAY CHASE IMMUNO SUPPRESS DRUG |
| 2500 | TPL - PAY AND REPORT |
| 2501 | SUSPEND FOR TPL REVIEW |
| 2502 | FILE CLAIM WITH MEDICARE |

| EOB Code | Description |
|---|---|
| 2503 | THIS PATIENT HAS OTHER INSURANCE |
| 2505 | CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT. |
| 2507 | EPSDT-MAY HAVE TPL |
| 2508 | TPL PAY AND CHASE PHARMACY |
| 2509 | TPL PAY AND CHASE PRE-NATAL |
| 2510 | THIS PATIENT HAS TWO COVERAGE TYPES |
| 2518 | PROVIDER TYPE - CLAIM INPUT CONFLICT |
| 2519 | DRUG REQUIRES PRIOR AUTHORIZATION |
| 2520 | DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED |
| 2522 | MEMBER IS NOT ELIGIBLE FOR THESE SERVICES |
| 2524 | OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE |
| 2526 | PCS PRIOR AUTHORIZATION NOT ON FILE |
| 2527 | PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES |
| 2528 | PCS PRIOR AUTHORIZATION UNITS USED |
| 2530 | TIER 2 NSAID NO RECORD OF TIER 1'S ON FILE |
| 2532 | DISEASE STATE MANAGEMENT |
| 2533 | PDUR DRUG-ALLERGY INTERACTION |
| 2534 | PRODUR DRUG-AGE INTERACTION |
| 2535 | PDUR INGREDIENT DUPLICATION |
| 2536 | PDUR THERAPEUTIC DUPLICATION |
| 2537 | PDUR DRUG-TO-DRUG INTERACTION |
| 2538 | HMO CO-PAY/MEMBER HAS TPL |
| 2539 | PDUR EARLY REFILL ON PRESCRIPTION |
| 2540 | PDUR MINIMUM DURATION OF THERAPY |
| 2541 | PDUR DOSING PRECAUTION-HIGH DOSE |
| 2542 | PDUR DOSING PRECAUTION-LOW DOSE |
| 2543 | PDUR BREAST FEEDING/PREGNANCY PRECAUTION |
| 2544 | PDUR MAXIMUM DURATION OF THERAPY |
| 2545 | PDUR LATE REFILL ON PRESCRIPTION |
| 2546 | DRUG DISEASE MARKER |
| 2547 | HMO CO-PAY/MEMBER HAS MEDICARE |
| 2548 | PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP |
| 2549 | ADJUSTMENT SUSPEND FOR MANUAL REVIEW |
| 2550 | SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER |
| 2552 | PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID |
| 2555 | CLAIM PAST 24 MONTH FILING - DTL |
| 2556 | MEMBER IS NOT WAIVER ELIGIBLE |
| 2557 | CLAIM PAST 24 MONTH FILING - HDR |
| 2560 | MEMBER SERVICES COVERED BY HMO PLAN |
| 2561 | PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY |
| 2562 | MEMBER PCPCM-CANNOT BILL OP/RHC/FQHC CLINICS RATE |
| 2563 | MEMBER NOT ENROLLED IN HMO FOR DOS |
| 2564 | SUPPLEMENTAL DELIVERY PYMT DENIAL CODE |
| 2566 | EXCEPTION CODE 566 |
| 2567 | HMO CO-PAY/NO TPL OR MEDICARE COVERAGE |
| 2569 | CC CLAIMS CAN'T PROCESS THRU SYSTEM |
| 2570 | INVALID ELIGIBILITY FOR HMO COPAY |
| 2571 | CLAIMCHECK REBUNDLED |
| 2572 | CC INCIDENTAL TO PRIMARY PROCEDURE |
| 2573 | CC MUTUALLY EXCLUSIVE |
| 2574 | CLAIMCHECK COSMETIC SURGERY |
| 2575 | CLAIMCHECK DUPLICATE |
| 2576 | CC UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED |
| 2577 | CLAIMCHECK POSSIBLE DUPLICATE |
| 2578 | CLAIMCHECK PRE-OP/POST-OP |
| 2579 | CC GROUPHEALTH SMARTSUSPENSE SUSPEND |
| 2580 | CLAIMCHECK MEDICAL/EVALUATION VISIT |
| 2581 | MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN |
| 2582 | MEMBER IS LOCKED-IN TO ANOTHER PHARMACY |
| 2583 | CLAIMREVIEW NEW VISIT FREQUENCY |
| 2584 | CC GROUPHLTH SMARTSUSPENSE DENY |
| 2587 | CLAIMREVIEW INTENSITY OF SERVICE |
| 2588 | STOP LOSS NOT APPROVED |
| 2589 | CC INVALID MODIFIER/PROCEDURE COMBINATION |
| 2590 | CLAIMCHECK EXCEEDS 40 LINES |
| 2591 | CLAIMREVIEW MULTIPLE/DUPLICATE COMP.BILLING |
| 2592 | CLAIMCEHCK AGE REPLACEMENT |
| 2593 | CLAIM REVIEW DIAGNOSIS TO PROCEDURE |
| 2594 | CLAIMCHECK-BILL EACH DOS ON A SEPARATE LINE |
| 2595 | CLAIMCHECK AGE CONFLICT |
| 2597 | CLAIMCHECK MULTIPLE SURGERY |
| 2598 | CC-MULTIPLE SURGERY-DOUBLE MODIFIERS |
| 2599 | STOP LOSS THRESHOLD REACHED |
| 2600 | UNITS NOT EQUAL TO TEETH BILLED |
| 2601 | PART A CROSSOVER SPANS 20020501 |
| 2602 | UNITS NOT EQUAL TO TEETH BILLED |
| 2603 | PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA |
| 2604 | SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH |
| 2605 | PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH |
| 2606 | PRIOR AUTH UNITS/AMOUNTS USED |

| EOB Code | Description |
|---|---|
| 2609 | CHECK CLAIM ATTACHMENT |
| 2612 | TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA |
| 2614 | DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS |
| 2615 | CLINIC RATE NOT ON FILE FOR HOSPITAL |
| 2616 | PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON |
| 2618 | AUTH SERVICES-MEMBER NOT ELIG |
| 2619 | MEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND |
| 2620 | MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM |
| 2622 | MASS CREDIT/ADJ BEING SUSPEND |
| 2623 | ADJUSTMENT HAS AUTO DENIAL |
| 2625 | FUND CODE UNDETERMINED |
| 2627 | COVERED FOR ORAL PATH ONLY |
| 2628 | DRUG REQUIRES PRIOR AUTHORIZATION/MN |
| 2630 | DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM |
| 2631 | DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM |
| 2632 | DIAGNOSIS NOT IN SCOPE OF CN PROGRAM |
| 2633 | DIAGNOSIS NOT IN SCOPE OF MN PROGRAM |
| 2634 | DETAIL ATTENDING PHYSICIAN ID INVALID |
| 2635 | DETAIL FIRST OTHER PHYSICIAN ID INVALID |
| 2636 | DETAIL SECOND OTHER PHYS ID INVALID |
| 2638 | DRUG REQUIRES MEDICAL REVIEW/CN |
| 2639 | DRUG REQUIRES MEDICAL REVIEW/MN |
| 2642 | INVALID PROVIDER NUMBER |
| 2643 | ABORTION REQUIRES REVIEW |
| 2644 | PROCEDURE CODE MODIFIER NOT PAYABLE |
| 2646 | PROVIDER RATE NOT ON FILE |
| 2648 | CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE |
| 2649 | FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS |
| 2651 | INVALID TREATMENT DIAGNOSIS INDICATOR |
| 2652 | PCS-INVALID NET CLAIM CHARGE |
| 2653 | MEMBER ID IS INVALID FOR AUTH EXAM |
| 2654 | MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD |
| 2655 | ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH |
| 2657 | POTENTIAL DISABILITY CLAIM |
| 2659 | DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD |
| 2660 | ZERO AMOUNT TO PAY |
| 2673 | SUBMIT PAPER CLAIM |
| 2681 | PROVIDER INELIGIBLE ON DATE OF SERVICE |
| 2696 | CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY |
| 2697 | QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY |
| 2701 | PHYSICAN SIGNED CONSENT FORM BEFORE STERILIZATION |
| 2702 | DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM |
| 2703 | MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM |
| 2704 | REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION |
| 2705 | STERILIZATION CONSENT FORM IS NOT LEGIBLE |
| 2706 | DATE ON THE CONSENT FORM IS NOT LEGIBLE |
| 2707 | STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING |
| 2708 | PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM |
| 2709 | CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION |
| 2710 | CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION |
| 2711 | STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN |
| 2712 | CONSENT FORM IS NOT SIGNED BY THE MEMBER |
| 2713 | CONSENT FORM IS NOT SIGNED BY THE COUNSELOR |
| 2714 | CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED |
| 2715 | STERILIZATION CONSENT FORM IS INCOMPLETE |
| 2716 | HYSTERECTOMY CONSENT FORM REQUIRED |
| 2717 | STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN |
| 2718 | INVALID SURGICAL PROCEDURE CODE |
| 2719 | REFILE CLAIM WITH OPERATIVE REPORT |
| 2720 | INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM |
| 2721 | FURTHER DESCRIPTION OF SERVICE REQUIRED |
| 2722 | STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ |
| 2723 | SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY |
| 2724 | REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES |
| 2725 | SERVICE NOT COVERED AS BILLED |
| 2726 | REFERRING PHYSICIAN REQUIRED |
| 2727 | ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES |
| 2728 | SERVICES ARE NOT AUTHORIZED |
| 2729 | DENIED AFTER SPECIAL REVIEW |
| 2730 | HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY |
| 2732 | COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER |
| 2733 | SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM |
| 2734 | PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION |
| 2735 | MEMBER INELIGIBLE ON SERVICE DATES |
| 2736 | MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW |
| 2737 | INVALID MODIFIER FOR THIS PROCEDURE |
| 2738 | INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE |
| 2739 | ONE AMBULATORY SURGERY ALLOWED PER DAY |
| 2740 | INVALID CODE FOR NARRATIVE DESCRIPTION |
| 2741 | INVALID SUBMITTED CHARGE |

| EOB Code | Description |
|---|---|
| 2742 | AUTHORIZED PHYSICAL REQUIRES ABCDM-16 |
| 2743 | EXCEPTION CODE 743 |
| 2744 | AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16 |
| 2745 | REQUESTED ADDITIONAL INFORMATION NOT RECEIVED |
| 2746 | DENTAL X-RAYS ARE REQUIRED |
| 2747 | SERVICES ARE INCLUDED IN TOTAL PAID OB CARE |
| 2748 | PROCEDURE IS AN INCIDENTAL TO PAID MAJOR SURGERY |
| 2749 | OUTSIDE THE GUIDELINES OF THE MEDICAL PROGRAM |
| 2750 | EXCEEDS SUPPLY LIMIT/1 MONTH WITHIN 12 MONTHS |
| 2751 | EXCEPTION CODE 751 |
| 2752 | PER PHY MANUAL-USE 99202 ANTEPART WHEN NOT TOT. OB |
| 2753 | PROCEDURE IS INCIDENTAL MAJOR PROCEDURE ON CLAIM |
| 2754 | REFILE USING "MEMBER AREA" IN SQ CM |
| 2755 | REFILE CLAIM WITH PROOF OF TIMELY FILING ATTACHED |
| 2756 | EXCEPTION CODE 756 |
| 2757 | TAKE HOME MEDICATION IS NOT PAYABLE |
| 2758 | PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER |
| 2759 | NEEDS COUNTY ADMIN AND/OR PROVIDER SIGNATURE |
| 2760 | MEMBER IS DECEASED THIS DATE OF SERVICE |
| 2761 | NAME ON SUBMITTED CLAIM DOES NOT MATCH DHS FILE |
| 2762 | FILE AN ASSIGNED MEDICARE CLAIM ON THIS PATIENT |
| 2763 | PCS - HEALTH CARE AUTHORITY WILL PROCESS CLAIM |
| 2764 | DUPLICATE OF PAID CLAIM |
| 2765 | INVALID HYSTERECTOMY CONSENT FORM |
| 2766 | STERILIZATION/HYSTERECTOMY CONSENT FORM IS INVALID |
| 2767 | EXCEPTION CODE 767 |
| 2768 | REQUEST ADJUSTMENT TO PAID CLAIM-PER MANUAL |
| 2769 | PAYMENT CORRECTED/SPENDDOWN-ADM12-HIST ONLY ADJUST |
| 2770 | INSURANCE PAYMENT MORE THAN ALLOWABLE |
| 2771 | SERVICE NOT PAYABLE THIS DATE OF SERVICE |
| 2772 | TYPE OF BILL-CLAIM CONFLICT |
| 2773 | AUTHORIZED ROOM & BOARD SERVICES ARE NOT ON CLAIM |
| 2774 | EXCEPTION CODE 774 |
| 2775 | CLAIM HAS BEEN FORWARED TO HCA |
| 2777 | SHOW MEDICARE PART B PAYMENTS |
| 2778 | HEALTH CARE AUTHORITY PROCESSED ADM12 |
| 2779 | ELIGIBILITY PROBLEM PROCESSED BY DHS |
| 2780 | RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS |
| 2781 | ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH |
| 2782 | PART OF INPATIENT HOSPITAL CHARGES |
| 2783 | PROCEDURE INCLUDED IN OFFICE CALL |
| 2785 | ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION |
| 2786 | SAME NDC/DATE PAID THIS PHARM |
| 2787 | ASST SURGEON MUST FILE OWN CLM |
| 2788 | CLINIC VISIT PAID THIS DATE |
| 2789 | PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN |
| 2790 | ABCDM-16/CLAIM PROV CONFLICT |
| 2791 | INVALID DIAGNOSIS FOR DESCRIPTION |
| 2792 | STERILIZATION CONSENT REQUIRED |
| 2793 | SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE |
| 2794 | PAID CLAIM INCLUDED THIS PROCEDURE |
| 2795 | CC MUTUALLY EXCLUSIVE |
| 2796 | PATIENT HAS PRIVATE INSURANCE |
| 2797 | MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS |
| 2798 | REFILE WITH MEDICARE RECHECK HIC NUMBER |
| 2799 | EXCEPTION CODE 799 |
| 2800 | PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2801 | PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2802 | PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2803 | DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2804 | DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2806 | PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2807 | PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2808 | MEMBER IS ELIGIBLE FOR HOSPICE FOR A PORTION OF THE DATES OF SERVICE BILLED. PLEASE CORRECT AND RESUBMIT. |
| 2812 | CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2813 | EXCEPTION CODE 813 |
| 2814 | CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2815 | LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM |
| 2816 | LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2820 | PCS-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2821 | PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2822 | EXCEPTION CODE 822 |
| 2823 | OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2824 | OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2826 | HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2827 | EXCEPTION CODE 827 |
| 2828 | HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM |
| 2829 | INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2830 | INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2831 | EXCEPTION CODE 831 |

| EOB Code | Description |
|---|---|
| 2832 | TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2833 | TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2835 | CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2836 | CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2838 | LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2839 | LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2842 | DEALER-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2843 | DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2845 | OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM |
| 2846 | OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM |
| 2849 | INVALID MODIFIER COMBINATION |
| 2850 | LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM |
| 2851 | LTC-HOME HEALTH CLAIM CONFLICT |
| 2852 | LTC-PCS POSSIBLE CONFLICT |
| 2853 | PCS-LTC POSSIBLE CONFLICT |
| 2854 | INPATIENT-PCS POSSIBLE CONFLICT |
| 2855 | PCS-INPATIENT POSSIBLE CONFLICT |
| 2856 | HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM |
| 2857 | INPT/CROSSOVER POSSIBLE CONFLICT CROSSOVER/INPT |
| 2858 | INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM |
| 2859 | EXCEPTION CODE 859 |
| 2860 | CROSS CLAIM TYPE J CODE CONFLICT |
| 2877 | REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK |
| 2880 | PRODEDURE CODE NOT VALID FOR FORM |
| 2881 | HOME HEALTH-LTC CLAIM CONFLICT |
| 2882 | LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM |
| 2883 | CROSSOVER-PCS POSSIBLE CONFLICT |
| 2884 | PCS-CROSSOVER POSSIBLE CONFLICT |
| 2889 | PART-A COINSURANCE GREATER MEDICARE PD AMT |
| 2890 | REVIEW CROSSOVER PART B COINSURANCE OVER $1000.00 |
| 2893 | EXCEPTION CODE 893 |
| 2894 | RURAL HEALTH REVENUE REQUIRES HCPC CODE |
| 2895 | RURAL HEALTH CLINIC REQUIRES REVENUE OP521 |
| 2896 | FILE SEPARATE CLAIMS FOR DIFFERENT YEARS |
| 2900 | PCS DAYS REDUCED-INPT/LTC CONFLICT |
| 2901 | FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS |
| 2903 | MULTIPLE CPT CODES REQUIRED |
| 2904 | DENIED FOR OKLA FOUNDATION FOR PEER REVIEW AUDIT |
| 2905 | REFILE SEPARATE CLAIM FOR EACH MONTH |
| 2906 | MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS |
| 2907 | PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE |
| 2908 | ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE |
| 2909 | FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER |
| 2910 | PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA |
| 2911 | SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT |
| 2912 | CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW |
| 2913 | CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW |
| 2914 | SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM |
| 2915 | PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM |
| 2916 | EXCEPTION CODE 916 |
| 2917 | CHARGES INDICATE ERROR IN MATH |
| 2918 | INDICATE UNITS WORKED NOT DAYS |
| 2919 | FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE |
| 2920 | WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION |
| 2921 | LIST EACH DATE SEPARATELY |
| 2922 | PATIENT RECEIVED SETTLE/BILL PATIENT |
| 2923 | ITEMIZE CHARGES FOR SUPPLIES |
| 2924 | CLIENT RESPONSIBLE EXCEEDS ALLOWABLE |
| 2925 | MEDICAL CONDITION/DIAGNOSIS NOT COVERED |
| 2926 | DME/MSEA NAME BRAND DOES NOT MATCH ORDER NUMBER |
| 2927 | INDICATE EXACT UNITS PROVIDED FOR MEMBER |
| 2928 | WHOLESALER'S INVOICE REQUIRED FOR PAYMENT |
| 2929 | PROC/DIAG REQUIRE FEDERAL MANDATED STATMT-ABORTION |
| 2930 | PROCEDURE UNITS REDUCED TO ALLOWABLE |
| 2931 | EXCEPTION CODE 931 |
| 2932 | DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM |
| 2933 | ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS |
| 2934 | CLAIM WAS FILED WITH INVALID PROVIDER NUMBER |
| 2935 | RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH |
| 2936 | CONTACT CASE MANAGER OR SUPERVISOR |
| 2937 | PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE |
| 2938 | EXCEPTION CODE 938 |
| 2939 | REFILE ON PAPER CLAIM |
| 2940 | SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING |
| 2941 | REFILE WITH MEDICARE REMITTANCE STATEMENT |
| 2942 | DUPLICATE PAID THRU FINANCE |
| 2943 | REFILE ON ADM84-TRANSPORTATION CLAIM FORM |
| 2944 | DENIED AFTER CLAIM CHECK REVIEW |
| 2945 | INVALID PROOF OF DENIAL/HMO |
| 2946 | INVALID PROOF OF INSURANCE DENIAL |

| EOB Code | Description |
|---|---|
| 2947 | REFILE WITH CORRECT ADMIT DATE |
| 2948 | RESUBMIT LEGIBLE CLAIM/ATTACHMENT |
| 2949 | EXCEPTION CODE 949 |
| 2950 | THIS LEVEL TRANSPORTATION NOT REQUIRED |
| 2951 | DDSD WILL PROCESS CLAIM THROUGH FINANCE |
| 2952 | REFILE-NAME BRAND & PRODUCT/ORDER NUMBER FOR PRICE |
| 2953 | REFILE AS CROSSOVER WITH EOMP |
| 2954 | REFILE WITH APPROPRIATE EOMP |
| 2955 | NOT ELIGIBLE FOR WAIVERED SERVICES |
| 2956 | TPL PAID COLLECT FROM PATIENT |
| 2957 | NOT VERIFIED BY OPERATIVE REPORT |
| 2958 | ITEMIZE SURGERIES PER OPERATIVE REPORT |
| 2959 | CANNOT PROCESS NEGATIVE AMOUNTS |
| 2960 | ADJUSTED PER OFPR RECOMMENDATION |
| 2961 | NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN |
| 2962 | DOCUMENT OF NECESSITY/MRI REPORT REQUIRED |
| 2963 | DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE |
| 2964 | REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND |
| 2965 | PAY REMAINING DAYS ON PARAMETER FILE |
| 2966 | FILE MEDICARE PART A FOR INPATIENT SERVICES |
| 2967 | PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP |
| 2968 | REFILE AS PHARMACY WITH NATIONAL DRUG CODE |
| 2969 | NO MEDICAL JUSTIFICATION FOR TARGETED OB US |
| 2970 | SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION |
| 2971 | PARTIAL HOURS NON ACCEPTABLE |
| 2972 | NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL |
| 2973 | REFILE AS AMBULATORY SURGERY |
| 2974 | PRESCRIBING PROVIDER EXCLUDED |
| 2976 | HYSTERECTOMY REQUIRE SIGN DATE |
| 2977 | REFILE CLAIM WITH MEDICAL RECORD |
| 2978 | INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE |
| 2979 | NURSING HOME CLAIMS PAID THIS DATE OF SERVICE |
| 2980 | PROCEDURE NOT PAYABLE FOR THIS AGE |
| 2981 | VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE |
| 2982 | REFILE WITH PHYSICIAN PROGRESS NOTES |
| 2983 | PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA |
| 2984 | DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE |
| 2985 | PROVIDER IS SUSPENDED OR TERMINATED |
| 2986 | UNITS CANNOT BE GREATER THAN 999 |
| 2987 | PRIOR AUTHORIZATION UNITS/AMOUNTS USED |
| 2988 | TB ONLY ELIGIBLE - NEED 'T' IN FORCE FIELD (FF) |
| 2989 | SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH |
| 2990 | SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER |
| 2991 | UNITS REDUCED PER DOCU/AFTER SURS REVIEW |
| 2993 | EXCEPTION CODE 993 |
| 2994 | EXCEPTION CODE 994 |
| 2995 | EXCEPTION CODE 995 |
| 2996 | EXCEPTION CODE 996 |
| 2997 | EXCEPTION CODE 997 |
| 2998 | EXCEPTION CODE 998 |
| 2999 | EXCEPTION CODE 999 |
| 3000 | UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTHORIZATION MASTER. |
| 3001 | PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM DETAIL. |
| 3003 | SERVICE REQUIRES PRIOR AUTHORIZATION. |
| 3006 | DOLLARS EXCEED AUTHORIZED DOLLARS ON AUTHORIZATION MASTER. |
| 3037 | MEMBER NUMBER HAS BEEN DEACTIVATED |
| 3201 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR PRIMARY DIAGNOSIS. |
| 3202 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SECOND DIAGNOSIS. |
| 3203 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRD DIAGNOSIS. |
| 3204 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTH DIAGNOSIS. |
| 3205 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTH DIAGNOSIS. |
| 3206 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTH DIAGNOSIS. |
| 3207 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTH DIAGNOSIS. |
| 3208 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTH DIAGNOSIS. |
| 3209 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINTH DIAGNOSIS. |
| 3210 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TENTH DIAGNOSIS. |
| 3211 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR ELEVENTH DIAGNOSIS. |
| 3212 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWELFTH DIAGNOSIS. |
| 3213 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR THIRTEENTH DIAGNOSIS. |
| 3214 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FOURTEENTH DIAGNOSIS. |
| 3215 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR FIFTEENTH DIAGNOSIS. |
| 3216 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SIXTEENTH DIAGNOSIS. |
| 3217 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR SEVENTEENTH DIAGNOSIS. |
| 3218 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR EIGHTEENTH DIAGNOSIS. |
| 3219 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR NINETEENTH DIAGNOSIS. |
| 3220 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTIETH DIAGNOSIS. |
| 3221 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIRST DIAGNOSIS. |
| 3222 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-SECOND DIAGNOSIS. |
| 3223 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-THIRD DIAGNOSIS. |
| 3224 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FOURTH DIAGNOSIS. |

| EOB Code | Description |
|---|---|
| 3225 | CLAIM DENIED. PRESENT ON ADMISSION (POA) INDICATOR MISSING OR INVALID FOR TWENTY-FIFTH DIAGNOSIS. |
| 3226 | CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS DMESUPPLIER SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBER. |
| 3227 | CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBER. |
| 3228 | CLAIM DETAIL DENIED. UNITS OF SERVICE EXCEED NCCI MUE LIMITATION FOR THIS OUTPATIENT HOSPITAL SERVICE. THIS DENIED SERVICE SHOULD NOT BE BILLED TO THE MEMBE |
| 3229 | CLAIM/DETAIL DENIED. DIAGNOSIS CODE INVALID FOR THIS DRUG. |
| 3230 | MEDICAL DIRECTION FOR ANESTHESIA IS NOT COVERED. |
| 3233 | CLAIM/DETAIL DENIED. NOT ALLOWED TO SUBMIT EVV SERVICES. |
| 3234 | CLAIM/DETAIL DENIED. ATTACHMENT NOT RECEIVED. |
| 3236 | MEDICARE COPAY + COINSURANCE + DEDUCTIBLE GREATER THAN ESTABLISHED LIMIT. PLEASE VERIFY THE AMOUNT(S) YOU ENTERED ARE CORRECT. |
| 3237 | NO MATCHING EVV RECORD FOUND FOR THIS SERVICE. |
| 3238 | CLAIM SERVICE UNITS EXCEED THE EVV UNITS. |
| 3239 | THIS SERVICE MUST BE SUBMIITED WITH EITHER "FREECARE99" OR "IEP", AS APPLICABLE, INDICATED IN THE HEADER PRIOR AUTHORIZATION NUMBER FIELD. |
| 3240 | RE-ENTRY ORGANIZATION CLAIMS NOT PAYABLE FOR THIS MEMBER. |
| 3301 | TOTAL CLAIM BILLED EXCEEDS DOLLAR LIMIT ($99,000) |
| 3315 | NURSING FACILITY RATE NOT ON FILE FOR THE DATE OF SERVIVE(S) BILLED. |
| 3340 | UB-04 CLAIMS MUST INCLUDE AT LEAST ONE VALID REVENUE CODE. |
| 3354 | LTC PROVIDER NUMBER MUST BE ENTERED. |
| 3360 | TAXONOMY CODE INVALID |
| 3362 | PA NUMBER OR PA PAYMENT METHOD IS NOT VALID |
| 3371 | THE DISCHARGE HOUR IS MISSING OR INVALID. |
| 3382 | THIS DIAGNOSIS IS NOT PAYABLE FOR THIS PROVIDER TYPE. |
| 3385 | MODIFIER IS INVALID FOR MEMBER'S GENDER. |
| 3398 | SERVICE(S) NOT COVERED BY KY MEDICAID. DIAGNOSIS CODE INDICATES SUBSTANCE ABUSE/CHEMICAL DEPENDENCY. |
| 3399 | SERVICE NOT COVERED FOR THE RENDERING PROVIDER NUMBER. |
| 3400 | RENDERING PROVIDER TYPE INVALID FOR GROUP/CLINIC |
| 3402 | THE FOLLOWING CODES ARE REIMBURSED THROUGH THE PHARMACY PROGRAM: A4206, A4210,A4250, A4252, A4253, A4256, A4258, A4259, E0607 AND E2100. |
| 3404 | THE BILLING PROVIDER IS NOT ENROLLED TO THE MCO. |
| 3405 | PATIENT ACCOUNT NUMBER MUST BE ENTERED IN THE MEDICAL RECORD NUMBER FIELD ON PROFESSIONAL AND INSTITUTIONAL ENCOUNTERS. |
| 3406 | DELIVERY DIAGNOSES INCOMPLETE WITHOUT A REPORT OF PREGNANCY WEEKS OF GESTATION.PLEASE RESUBMIT WITH DIAGNOSIS SUPPORTING EARLY ELECTIVE DELIVERY OR ON PAPER |
| 3407 | EARLY DELIVERY NOT PAYABLE FOR THIS DIAGNOSIS CODE(S). PLEASE RESUBMIT WITH MEDICAL DOCUMENTATION SHOWING REASON FOR EARLY DELIVERY. |
| 3408 | PHYSICIAN ADMINISTERED DRUG RATES ARE NOT ON FILE FOR THIS PROCEDURE CODE/NDC COMBINATION. |
| 3409 | PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE REQUIRES NDC. |
| 3410 | NDC NOT VALID FOR PHYSICIAN ADMINISTERED DRUG (PAD) PROCEDURE CODE. |
| 3411 | NDC IS RATED DESI. |
| 3412 | NDC IS NOT REBATE-ELIGIBLE. |
| 3413 | NDC NOT VALID FOR DATE OF SERVICE. |
| 3414 | NDC IS OBSOLETE. |
| 3415 | UNITS OF SERVICE CANNOT EXCEED THE NUMBER OF DETAIL DAYS BILLED AND CANNOTINCLUDE DISCHARGE DATE. |
| 3416 | REVENUE CODE 169 MAY NOT BE BILLED WITH OTHER ACCOMMODATION REVENUE CODES. |
| 3417 | THE SCHOOL-BASED SERVICES DATA TO INDICATE THE SERVICE AS "EXPANDED ACCESS" CANNOT BE SUBMITTED IN THE DETAIL. THE EXPANDED ACCESS SERVICE INDICATOR "FREECAR |
| 3418 | CCBHC CLAIM HAS ERRORS. PLEASE CORRECT ALL ERRORS AND RESUBMIT THE ENTIRE CLAIM. |
| 3419 | THIS PROCEDURE CODE REQUIRES AN NDC. THE NDC IS MISSING OR IS NOT ON FILE. |
| 3420 | ANESTHESIA PROCEDURES REQUIRE AN APPROPRIATE MODIFIER |
| 3421 | MODIFIER Q2 IS NOT BILLABLE ON COMMUNITY MENTAL HEALTH CENTER CLAIMS. |
| 3422 | PROCEDURE CODE T1040 IS NOT BILLABLE FOR COMMUNITY MENTAL HEALTH CENTER (PROVIDER TYPE 30) SERVICES. |
| 3423 | MODIFIER CR IS ONLY ALLOWED WITH PROCEDURE CODE 99401. |
| 3424 | FAILS TO MEET DMS CRITERIA. PLEASE CONTACT DMS AT DMSPHARMACY@KY.GOV. |
| 3425 | MCO ADJUDICATION DATE IS MISSING/INVALID |
| 3426 | TOTAL MCO PAID AMOUNT FOR ALL DETAILS MUST BE GREATER THAN $0.01. |
| 3580 | THIS DRUG IS NOT COVERED FOR THIS PROVIDER. |
| 3590 | MODIFIER 33 IS ONLY BILLABLE WITH CERTAIN PROCEDURE CODES OR PROCEDURE CODE/DIAGNOSIS CODE/AGE/GENDER COMBINATIONS. |
| 3591 | MODIFIERS HM, U2, AND U6 ARE NOT BILLABLE ON PRIMARY CARE CENTER AND RURAL HEALTH CENTER CLAIMS. |
| 3592 | T2005 AND T2005 GM REPLACED WITH A0428 OR A0428 GM. |
| 3593 | MODIFIER GT MUST BE BILLED WITH MODIFIER AH, AJ, SA, UA, U1, U2 OR U9. EFFECTIVE 1/1/2014 MODIFIER GT MUST BE BILLED WITH MODIFIER AF, AH, AJ, AM, HO, SA, U2 |
| 3594 | DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES OR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE, AND |
| 3595 | THE NUMBER OF UNITS BILLED FOR THIS PROCEDURE IS IN EXCESS OF THE THRESHOLD SETBY DMS TO AUTOMATICALLY INITIATE A SUSPENSION AND REVIEW OF THE CLAIM. |
| 3596 | TYPE OF BILL 110 NOT VALID FOR DRG CLAIMS. |
| 3597 | CLAIM/DETAIL DENIED. MFP MEMBER PLAN AND PROGRAM CODE DO NOT CORRESPOND. PLEASE CONTACT THE DEPARTMENT FOR MEDICAID SERVICES AT 502-564-5560. |
| 3598 | TOOTH NUMBER IS NOT VALID FOR PROCEDURE CODE AND PROVIDER TYPE. |
| 3599 | THIS SERVICE IS NOT COVERED WHEN PROVIDED BY A PHYSICIAN ASSISTANT. |
| 3600 | SERVICE NOT COVERED UNDER MEMBER'S PROGRAM. |
| 3601 | MEMBER'S ELIGIBILITY IS SUSPENDED DUE TO INCARCERATION. |
| 3602 | MEMBER IS ELIGIBLE BUT DIS-ENROLLED DUE TO ADDRESS MISMATCH. |
| 3610 | DETAIL DENIED. DATE OF SERVICE MUST BE EQUAL TO OR WITHIN SIX DAYS PRIOR TO MEMBER'S DATE OF DEATH. |
| 3611 | DETAIL DENIED. THIS REVENUE CODE REQUIRES THE ENTRY OF OCCURRENCE CODE 55 WITHA CORRESPONDING OCCURRENCE DATE INDICATING MEMBER'S DATE OF DEATH. |
| 3612 | PATIENT STATUS CODE 20, 40, 41, OR 42 MUST BE ENTERED ON HOSPICE CLAIMS WITH THIS REVENUE CODE. |
| 3836 | DETAIL DENIED. MODIFIERS LT AND RT CANNOT BE BILLED ON THE SAME DETAIL LINE. |
| 3837 | PLACE OF SERVICE CODE 42 NOT VALID FOR NON-EMERGENCY TRANSPORTATION CLAIMS. |
| 3838 | RADIOLOGY PROCEDURE CODE NOT ALLOWED TO BILL WITH MODIFIER COMBINATION TC AND 26. |
| 3996 | NDC IS TERMINATED. |
| 3999 | CLAIM BILLED WITH INACTIVE MID |
| 4000 | MORE THAN TWO SURGICAL UNITS ON THE CLAIM |
| 4002 | THIS NDC CODE IS NOT COVERED FOR THIS MEMBER. |
| 4003 | DRUG IS LESS THAN EFFECTIVE - DESI |
| 4008 | NDC IS OBSOLETE |
| 4014 | NO PRICING SEGMENT IS ON FILE. |

| EOB Code | Description |
|---|---|
| 4017 | THIS DRG IS NOT COVERED FOR THIS MEMBER. |
| 4019 | PROCEDURE CODE REQUIRES ATTACHEMENT. |
| 4020 | UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE |
| 4021 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4026 | NDC/DAYS SUPPLY LIMITATIONS. THIS NDC CODE BILLED MAY NOT BE GREATER THAN THE NUMBER OF DAYS ALLOWED ON THE NDC FILE. |
| 4027 | DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE. |
| 4029 | DIAGNOSIS AND PLACE OF SERVICE DO NOT MATCH FOR THE MEMBER'S BENEFIT PLAN |
| 4031 | GENDER RESTRICTION FOR BILLED DIAGNOSIS. |
| 4033 | INVALID PROCEDURE CODE MODIFIER COMBINATION |
| 4039 | DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS |
| 4047 | FIFTH DIAGNOSIS CODE IS INVALID. |
| 4048 | SIXTH DIAGNOSIS CODE IS INVALID. |
| 4049 | SEVENTH DIAGNOSIS CODE IS INVALID. |
| 4050 | EIGHTH DIAGNOSIS CODE IS INVALID. |
| 4051 | NINTH DIAGNOSIS CODE IS INVALID. |
| 4052 | ADMITTING DIAGNOSIS CODE IS INVALID. |
| 4060 | E (EMERGENCY) DIAGNOSIS CODE IS INVALID. |
| 4061 | ADMITTING DIAGNOSIS CODE IS MISSING. |
| 4063 | ICD PROCEDURE CODE/AGE RESTRICTION. |
| 4064 | GENDER RESTRICTION FOR COVERED ICD PROCEDURE. |
| 4065 | ICD PROCEDURE REQUIRES ATTACHMENT. |
| 4067 | ICD SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE. |
| 4070 | MODIFIER RESTRICTION FOR REIMBURSEMENT RULE |
| 4077 | REVENUE CODE INVALID FOR DATE OF SERVICE. |
| 4089 | MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT |
| 4095 | NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL |
| 4098 | PRICING BEING REVIEWED |
| 4107 | REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PROVIDED |
| 4108 | NO ASC ON FILE |
| 4114 | PRICING BEING REVIEWED |
| 4115 | PRICING BEING REVIEWED |
| 4119 | VALUE CODE AMOUNT MISSING XYZ |
| 4120 | VALUE CODE IS MISSING |
| 4121 | PROCEDURE CODE REQUIRES TOOTH QUADRANT |
| 4122 | VALUE CODE IS INVALID |
| 4123 | VALUE CODE AMOUNT IS MISSING |
| 4124 | VALUE CODE AMOUNT IS INVALID |
| 4127 | CANNOT PRIORITIZE MEMBER'S PROGRAMS DUE TO SPAN-DATING. PLEASE RESUBMIT WITH EACH PROCEDURE CODE/SINGLE DATE OF SERVICE COMBINATION SUBMITTED ON A SINGLE LIN |
| 4140 | THIS PROVIDER MAY NOT BILL THIS SERVICE FOR THIS MEMBER. |
| 4141 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4142 | THIS REVENUE CODE IS NOT VALID FOR THIS PROVIDER CONTRACT. |
| 4182 | DRG GROUPER TYPE G NO LONGER VALID. |
| 4188 | THIS QUADRANT CODE IS NOT VALID FOR THIS PROCEDURE CODE. |
| 4189 | THIS ARCH CODE IS NOT VALID FOR THIS PROCEDURE CODE. |
| 4203 | THIS SERVICE IS A NON-COVERED OKLAHOMA HEALTH COVERAGE PROGRAM SERVICE AS THE RENDERING PROVIDER IS NOT RECOGNIZED BY THE OKLAHOMA HEALTH COVERAGE PROGRAM. |
| 4207 | CLIA NUMBER MISSING OR NOT ON FILE FOR DATE OF SERVICE. |
| 4209 | NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED |
| 4211 | PROCEDURE CODE/TOOTH NUMBER COMBINATION IS MISSING OR INVALID. |
| 4214 | CLAIM/DETAIL DENIED. CLIA NUMBER NOT SUBMITTED ON CLAIM. |
| 4215 | CLIA NUMBER SUBMITTED NOT ON FILE FOR BILLING PROVIDER. |
| 4216 | SUBMITTED CLIA NUMBER DOES NOT HAVE CORRECT CERTIFICATION. |
| 4218 | INVALID PROCEDURE FOR CLAIM FORM |
| 4220 | EPOGEN REQUIRES VALUE CODE 68 |
| 4227 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER. |
| 4244 | THIS DIAGNOSIS IS NOT COVERED FOR THIS MEMBER. |
| 4246 | ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE |
| 4251 | DECIMAL UNITS NOT BILLABLE FOR PROCEDURE. |
| 4252 | DIAGNOSIS CODE 10-24 NOT ON FILE |
| 4253 | REVENUE CODE REQUIRES MEDICAL REVIEW |
| 4254 | REVENUE CODE VS AGE RESTRICTION |
| 4255 | ONE OR MORE MODIFIERS ON THIS DETAIL CAN ONLY BE BILLED FOR MEMBERS AGED 21 AND YOUNGER |
| 4257 | THIS PROCEDURE CODE/MODIFIER COMBINATION IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4260 | ONE OR MORE OF THE EXTERNAL CAUSE OF INJURY DIAGNOSIS CODES IS INVALID. |
| 4261 | ONE OR MORE OF THE EXTERNAL CAUSE OF INJURY DIAGNOSIS CODES IS NOT ON FILE. |
| 4262 | ONE OR MORE OF THE PATIENT REASON FOR VISIT DIAGNOSIS CODES IS FORMATTED INCORRECTLY. |
| 4264 | ONE OR MORE OF THE PATIENT REASON FOR VISIT DIAGNOSIS CODES IS NOT ON FILE. |
| 4312 | PRIMARY DETAIL DIAGNOSIS CODE DOES NOT SUPPORT PROCEDURE CODE BILLED. |
| 4314 | DENIED. DIAGNOSIS CODE IS NOT COVERED. |
| 4316 | DIAGNOSIS CODE(S) DOES NOT SUPPORT PROCEDURE CODE BILLED. |
| 4318 | PRIMARY HEADER DX RESTRICTION FOR BILLED ICD PROCEDURE. |
| 4321 | PRIMARY HEADER DIAGNOSIS RESTRICTION FOR BILLED REVENUE CODE. |
| 4322 | DIAGNOSIS CODE NOT VALID FOR THIS REVENUE CODE. |
| 4330 | HEADER DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED. |
| 4331 | DETAIL DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED. |
| 4332 | HEADER DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED. |
| 4333 | DETAIL DIAGNOSIS(ES) DOES NOT SUPPORT SERVICE BILLED. |
| 4371 | THIS SERVICE IS COVERED FOR QMB ONLY MEMBERS. |
| 4374 | DENIED. REVENUE CODE IS NOT COVERED. |

| EOB Code | Description |
|---|---|
| 4376 | DENIED. ICD SURGICAL PROCEDURE CODE(S) IS NOT COVERED. |
| 4381 | NO REIMBURSEMENT RULE ON FILE. |
| 4384 | THE PRIMARY DIAGNOSIS ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT. |
| 4385 | MEMBER PLAN - PROCEDURE NOT BILLABLE WITH REVENUE CODE |
| 4386 | PROVIDER CONTRACT - PROCEDURE NOT BILLABLE WITH REVENUE CODE |
| 4387 | REIMBURSEMENT - PROCEDURE NOT PAYABLE WITH REVENUE CODE |
| 4391 | THE LENGTH OF STAY ON THE CLAIM IS NOT VALID FOR DRG ASSIGNMENT. |
| 4393 | CONTRACT INVALID REVENUE/PROCEDURE COMBO |
| 4394 | UNABLE TO DETERMINE REGULAR MEDICAID CLAIM TYPE FOR CROSSOVER CLAIM |
| 4395 | PROVIDER CONTRACT - PROCEDURE - OOS NOT COVERED |
| 4396 | PROVIDER CONTRACT - REVENUE CODE - OOS NOT COVERED |
| 4397 | PROVIDER CONTRACT - DRG - OOS NOT COVERED |
| 4398 | PROVIDER CONTRACT - ICD9 PROC - OOS NOT COVERED |
| 4400 | THE NDC IS NOT NUMERIC OR NOT FOUND IN THE DRUG FILE |
| 4401 | THIS NDC IS NOT VALID FOR THE DRUG GROUP FOR THIS PROCEDURE |
| 4402 | THE NDC IS MISSING OR IS NOT VALID FOR THIS J-CODE |
| 4403 | THE NDC QUANTITY IS MISSING OR ZERO. |
| 4404 | AWP NOT ON FILE FOR NDC |
| 4406 | THIS PROCEDURE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY. |
| 4407 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER PLAN/AID CATEGORY. |
| 4408 | A NATIONAL DRUG CODE (NDC) IS REQUIRED FOR THIS REVENUE CODE. |
| 4409 | DIAGNOSIS CODE(S) IS INVALID FOR DATE OF DISCHARGE. |
| 4410 | DIAGNOSIS CODE(S) IS INVALID FOR DATE OF ADMISSION. |
| 4411 | PICK-UP LOCATION INFORMATION IS MISSING OR INVALID. |
| 4412 | PICK-UP LOCATION ADDRESS LINE ONE IS MISSING. |
| 4413 | PICK-UP LOCATION CITY IS MISSING. |
| 4414 | PICK-UP LOCATION ZIP CODE IS MISSING OR INVALID. |
| 4415 | DROP-OFF LOCATION INFORMATION MISSING. |
| 4416 | DROP-OFF LOCATION ADDRESS LINE ONE IS MISSING. |
| 4417 | DROP-OFF LOCATION CITY IS MISSING. |
| 4418 | DROP-OFF LOCATION ZIP CODE IS MISSING OR INVALID. |
| 4419 | MCO PAID AMOUNT MISSING OR NOT GREATER THAN ZERO. |
| 4420 | MEMBER MANAGED CARE REGION CODE MISSING OR INVALID. |
| 4421 | ENCOUNTER SUBMITTER ID INVALID FOR THE DATE OF SERVICE |
| 4422 | THIS MEMBER HAS NO PLAN OF CARE SEGMENT FOR THE DATE OF SERVICE. |
| 4423 | THIS SERVICE IS NOT PAYABLE FOR WEEKEND DATES OF SERVICE. |
| 4424 | TENTH DIAGNOSIS CODE IS IN INVALID FORMAT. |
| 4425 | ELEVENTH DIAGNOSIS CODE IS IN INVALID FORMAT. |
| 4426 | TWELFTH DIAGNOSIS CODE IS IN INVALID FORMAT. |
| 4427 | TENTH DIAGNOSIS CODE IS NOT ON FILE. |
| 4428 | ELEVENTH DIAGNOSIS CODE IS NOT ON FILE. |
| 4429 | TWELFTH DIAGNOSIS CODE IS NOT ON FILE. |
| 4430 | THE ENCOUNTER DATA TYPE SUBMITTED IS NOT ACCEPTABLE FOR THE FILE TYPE. |
| 4431 | THIS PROCEDURE CODE IS NOT COVERED FOR THIS REVENUE CODE. |
| 4432 | NDC REQUIRED FOR THIS PROCEDURE CODE. |
| 4433 | TYPE OF BILL INVALID FOR CLAIM TYPE. |
| 4434 | MODIFIER 50 CANNOT BE BILLED WITH UNITS OF SERVICE GREATER THAN 1. |
| 4435 | MODIFIER U1 IS NOT VALID FOR PHYSICIAN CLAIMS FOR DATES OF SERVICE 10/01/2015 AND AFTER. PHYSICIAN ASSISTANT SERVICES FOR DATES OF SERVICE 10/01/2015 AND AFT |
| 4436 | MODIFIERS AS AND 80 CANNOT BE BILLED WITH MODIFIER SA. MODIFIER AS ALLOWED FORDOS 11/01/2023, AND AFTER. |
| 4437 | MODIFIER BILLED IS NOT COVERED FOR THIS PROVIDER TYPE. |
| 4438 | CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DOCUMENTATION REQUIRED DEPENDENT ON SPECIFIC REVENUE CODE AND CRITERIA SET FOR REVIEW. |
| 4439 | CCBHC SERVICES BILLED FOR SCHIP MEMBERS ARE NOT PAYABLE. |
| 4440 | DIAGNOSIS CODE(S) DOES NOT SUPPORT PROCEDURE CODE BILLED. |
| 4714 | AGE RESTRICTION FOR BILLED PROCEDURE. |
| 4715 | AGE RESTRICTION FOR BILLED REVENUE CODE. |
| 4750 | REVENUE CODE NOT COVERED FOR THIS MEMBER AND TYPE OF BILL. |
| 4760 | MEDICAL REVIEW RESTRICTION FOR BILLED ICD PROCEDURE. |
| 4765 | THIS ICD PROCEDURE IS NOT COVERED FOR THIS MEMBER. |
| 4801 | THIS PROCEDURE IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4802 | THE PROVIDER IS NOT ALLOWED TO BILL THIS DIAGNOSIS |
| 4804 | THIS REVENUE CODE IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4805 | THIS DRG IS NOT COVERED FOR THIS PROVIDER CONTRACT. |
| 4813 | MUST SUBMIT SPECIFIC DOCUMENTATION WHICH SUPPORTS THE PROCEDURE BEING PERFORMEDIN THIS SETTING VS. THE PHYSICIAN OFFICE SETTING. |
| 4831 | NO REIMBURSEMENT RULE ON FILE. |
| 4882 | THIS DRG IS NOT COVERED FOR THIS MEMBER. |
| 4886 | DENIED. DRG IS NOT COVERED. |
| 4975 | THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER. |
| 4980 | MEMBER BENEFIT AND ASSIGNMENT PLANS CONFLICT WITH EACH OTHER. |
| 4990 | THIS PROCEDURE CODE IS NOT COVERED FOR THIS MEMBER. |
| 5000 | THIS IS A DUPLICATE OF ANOTHER CLAIM. |
| 5001 | THIS IS A DUPLICATE OF ANOTHER CLAIM. |
| 5002 | THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT. |
| 5003 | THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL. |
| 5004 | REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL. |
| 5005 | REVERSAL NOT PROCESSED- MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER NUMBER AND DISPENSING DATE. PLEASE REFER TO YOUR POS MANUAL. |
| 5007 | THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJUSTMENT, PLEASE SUBMIT THE APPROPRIATE ADJUSTMENT REQUEST FORM. |
| 5010 | EXACT DUPLICATE - TOOTH SURFACE |
| 5017 | ALL CCBHC SERVICES FOR THE SAME PROVIDER/MEMBER/DATE OF SERVICE COMBINATION MUST BE SUBMITTED ON A SINGLE CLAIM/ENCOUNTER. |
| 5100 | MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAVE BEEN PAID. NO ADDITIONAL VISITS WILL BE ALLOWED. |

| EOB Code | Description |
|---|---|
| 5101 | PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99213) |
| 5102 | PRICING ADJUSTMENT. CLAIM WAS PRICED AT A REDUCED RATE (99348) |
| 5110 | CLAIM DETAIL DENIED. MUST BILL INTRAORAL COMPLETE SERIES |
| 5111 | ENVIRONMENTAL ACCESSIBILITY SERVICES PAYMENT LIMITED TO $8,800.00 FOR THIS TIMEPERIOD. |
| 5112 | ENVIRONMENTAL ACCESSIBILITY SERVICES PAYMENT LIMITED TO $9,680.00 FOR THIS TIMEPERIOD. |
| 5113 | T2025 IS LIMITED TO $1,100.00 DURING AN SCL2 MEMBER?S PLAN OF CARE PERIOD. |
| 5114 | T2025 IS LIMITED TO $1,210.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD. |
| 5122 | PROCEDURE CODE L3030 IS LIMITED TO TWO PER LEG PER MEMBER PER CALENDAR YEAR. |
| 5124 | EYEWARE CODES V2100 THRU V2499 ARE LIMITED TO 4 UNITS (CUMULATIVELY) PER CALENDAR YEAR. |
| 5125 | CLAIM DETAIL DENIED. PROCEDURE CODE WITH MODIFIER LT IS LIMITED TO 2 UNITS PERMEMBER, PER CALENDAR YEAR. |
| 5126 | CLAIM/DETAIL DENIED. PROCEDURE CODE WITH MODIFIER RT IS LIMITED TO 2 UNITS PERMEMBER, PER CALENDAR YEAR. |
| 5127 | CLAIM/DETAIL DENIED. MONTHLY CONTACT LENSES WITH MODIFIER LT AND U1 ARE LIMITED TO 2 UNITS PER CALENDAR YEAR. |
| 5128 | CLAIM/DETAIL DENIED. REPLACEMENT MONTHLY CONTACT LENS WITH MODIFIER LT, U1, AND RA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5129 | CLAIM/DETAIL DENIED. DAILY CONTACT LENSES WITH MODIFIER LT AND U2 ARE LIMITED TO 4 UNITS PER CALENDAR YEAR. |
| 5130 | CLAIM/DETAIL DENIED. REPLACEMENT DAILY CONTACT LENS WITH MODIFIERS LT, U2 AND RA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5131 | CLAIM/DETAIL DENIED. BI-WEEKLY CONTACT LENS WITH MODIFIERS LT AND U3 LIMITED TO FOUR UNITS PER CALENDAR YEAR. |
| 5132 | CLAIM/DETAIL DENIED. REPLACEMENT BI-WEEKLY CONTACT LENS WITH MODIFIERS LT, U3 AND RA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5133 | CLAIM/DETAIL DENIED. MONTHLY CONTACT LENS WITH MODIFIER RT AND U1 ARE LIMITEDTO 2 UNITS PER CALENDAR YEAR. |
| 5134 | CLAIM/DETAIL DENIED. REPLACEMENT MONTHLY CONTACT LENS WITH MODIFIER RT, U1 ANDRA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5135 | CLAIM/DETAIL DENIED. DAILY CONTACT LENS WITH MODIFIER RT AND U2 ARE LIMITED TO4 UNITS PER CALENDAR YEAR. |
| 5136 | CLAIM/DETAIL DENIED. REPLACEMENT DAILY CONTACT LENS WITH MODIFIERS RT, U2 AND RA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5137 | CLAIM/DETAIL DENIED. BI-WEEKLY CONTACT LENS WITH MODIFIERS RT AND U3 LIMITED TO FOUR UNITS PER CALENDAR YEAR. |
| 5138 | CLAIM/DETAIL DENIED. REPLACEMENT BI-WEEKLY CONTACT LENS WITH MODIFIERS RT, U3 AND RA LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 5139 | PROCEDURE CODE S8189 IS LIMITED TO FOUR PER CALENDAR MONTH PER MEMBER. |
| 5140 | TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR HCBS2 MEMBER'S PLAN OF CARE YEAR. |
| 5141 | TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR SCL2 MEMBER'SPLAN OF CARE YEAR. |
| 5142 | CLAIM/DETAIL DENIED. HOME ADAPTATIONS ARE LIMITED TO $2420.00 PER ABI MEMBER'SPLAN OF CARE YEAR |
| 5143 | CLAIM/DETAIL DENIED. ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO $2420.00 PER ABI LTC MEMBER'S PLAN OF CARE YEAR. |
| 5144 | CLAIM/DETAIL DENIED. TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S PLAN OF CARE YEAR. |
| 5146 | TRANSPORTATION SERVICES ARE LIMITED TO $320.65 PER CALENDAR MONTH FOR AN SCL2 MEMBER. |
| 5147 | HOME DELIVERED MEALS ARE LIMITED TO 10 UNITS PER CALENDAR WEEK, PER MEMBER. |
| 5200 | VENI/ARTERIAL PUNCTURE SAME DATE OF SERVICE AS MONITORED PROCEDURE. |
| 5203 | CBC MAY NOT BE PAID ON SAME DAY AS CBC COMPONENTS. |
| 5214 | PROCEDURE CODES 93297 AND 93298 NOT ALLOWED SAME DOS. |
| 5217 | PROCEDURE CODES 93285 AND 93279, 93284 OR 93291 NOT ALLOWED SAME DOS. |
| 5219 | PROCEDURE CODE 93286 OR 93288 AND 93279-93281 NOT ALLOWED SAME DOS. |
| 5221 | PROCEDURE CODE 93287 OR 93289 AND 93282-93284 NOT ALLOWED SAME DOS. |
| 5222 | PROCEDURE CODE 93288 AND 93286, 93294, OR 93296 NOT ALLOWED SAME DOS. |
| 5223 | PROCEDURE CODE 93289 AND 93287, 93295 OR 93296 NOT ALLOWED SAME DOS. |
| 5224 | PROCEDURE CODE 93290 AND 93297 OR 93299 NOT ALLOWED SAME DOS. |
| 5235 | PROC S5100 & REV 580 NOT BILLABLE SAME MEMBER SAME DOS |
| 5236 | MONTHLY DIALYSIS NOT PAYABLE FOR SAME DATE OF SERVICE AS DAILY. |
| 5237 | PROCEDURE CODE 93293 AND 93294 NOT ALLOWED SAME DOS. |
| 5241 | PROCEDURES ARE NOT PAYABLE IN 30 DAYS OF RELATED PROCEDURES. |
| 5242 | PROCEDURE CODE 93291 AND 93288-93290, 93298 OR 93299 NOT ALLOWED SAME DOS. |
| 5244 | PROCEDURE CODE 93296 AND 93299 NOT ALLOWED SAME DOS. |
| 5246 | PROCEDURE CODES 93282 OR 93292 AND 93745 NOT ALLOWED SAME DOS. |
| 5249 | PROCEDURE CODE 93285 OR 93291 AND 33282 NOT ALLOWED ON THE SAME DOS. |
| 5250 | PROCEDURE CODE H0050 IS NOT ALLOWED ON THE SAME DOS AS PROCEDURE CODE H0001, 90791, 90792, 90845, 96105, 96110, 96111, 96116, 96125, 96150 OR 96151. |
| 5263 | RESPITE AND PERSONAL SERVICES CANNOT BE BILLED ON THE SAME DATE OF SERVICE AS RESIDENTIAL SERVICES. |
| 5265 | THERAPY SERVICES PERFORMED BY A THERAPIST CANNOT BE BILLED ON THE SAME DATE OFSERVICE AS THERAPY SERVICES PERFORMED BY A THERAPY ASSISTANT FOR SCL2 MEMBERS. |
| 5267 | PROCEDURE CODES H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. |
| 5269 | 09110/D9110 ON SAME DOS AS OTHER PROCEDURE. |
| 5270 | PROCEDURE CODE H2019 AND H2020 NOT ALLOWED ON THE SAME DATE OF SERVICE, SAME MEMBER. |
| 5271 | PAYMENT FOR PROCEDURE IS IN REIMBURSEMENT FOR SURGERY. |
| 5272 | PROCEDURE CODE NOT ALLOWED FOR DOS AS ADDITIONAL PROCEDURE. |
| 5273 | DETAIL DENIED. PROCEDURE CODE IS NOT ALLOWED FOR THE SAME MEMBER, SAME PROVIDER, SAME DATE OF SERVICE AS OTHER COVID-19 LAB PROCEDURE CODE BILLED. |
| 5275 | MILEAGE NOT ALLOWED ON THE SAME DATE OF SERVICE AS A0998 |
| 5278 | GENERAL SERVICES NOT PAYABLE ON SAME DOS AS SPECIAL. |
| 5284 | PROCEDURE CODE H2019 AND PROCEDURE CODE H2019, MODIFIER UG, ARE NOT ALLOWED ONTHE SAME DOS, SAME MEMBER. |
| 5290 | S5100 AND S5101 NOT BILLABLE SAME MEMBER SAME DOS |
| 5292 | HEMODIALYSIS NOT PAYABLE ON SAME DOS AS EVALUATION PROCEDURE. |
| 5295 | PROCEDURE CODES 00170 AND D9220 NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THESAME MEMBER. |
| 5297 | PROC CODES T1025 AND T1026 NOT PAYABLE ON SAME DOS. |
| 5300 | ADDITIONAL SERVICE CODES MUST BE BILLED IN CONJUNCTION WITH OTHER SPECIFIED PROCEDURE CODES. |
| 5302 | PERIODONTAL SACLING AND ROOT PLANNING (D4341) IS NOT ALLOWEDON SAME DATE OF SERVICE, SAME MEMBER, SAME PROVIDERAS PROPHYLAXIS (D1110, D1120, D1201) AND VICE V |
| 5303 | CLAIM DETAIL DENIED. HYSTERECTOMY PROCEDURE CODE 58565 IS NOT PAYABLE WHEN BILLED IN CONJUNCTION WITH PROCEDURE CODES 58555 OR 57800 AND VICE-VERSA. |
| 5304 | CLAIM DENIED. 29581 NOT PAYABLE ON SAME DATE OF SERVICE AS 29540 OR 29580. |
| 5305 | CLAIM DENIED. 36147 AND 36148 NOT PAYABLE ON SAME DOS AS 75791. |
| 5306 | CLAIM DENIED. 74261 AND 74262 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 74263, 76376, OR 76377. |
| 5307 | CLAIM DENIED. 87150 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 83890-83914. |
| 5308 | CLAIM DENIED. 88387 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 88388 OR 88329-88334. |
| 5309 | CLAIM DENIED. 74263 IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS 72192-72194,74150-74170, 76376, OR 76377. |
| 5310 | CLAIM DENIED. 92540 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92541, 92542, 92544, OR 92545. |
| 5311 | CLAIM DENIED. 92550 AND 92570 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 92567 OR 92568. |
| 5312 | CLAIM DENIED. 93750 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 33975, 33976, 33979, OR 33981-33983. |
| 5313 | CLAIM DENIED. 95905 NOT PAYABLE ON THE SAME DATE OF SERVICE AS 95900-95904 OR 95934-95936. |

| EOB Code | Description |
|---|---|
| 5314 | CLAIM DENIED. 64491 AND 64492 MUST BE BILLED IN CONJUNCTION WITH 64490 (SAME DATE OF SERVICE). |
| 5315 | CLAIM DENIED. 75557, 75559, 75561, 75563, AND 75565 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS 76376 OR 76377. |
| 5316 | CLAIM DENIED. 64494 AND 64495 MUST BE BILLED IN CONJUNCTION WITH 64493 (SAME DATE OF SERVICE). |
| 5317 | CLAIM DENIED. 75565 IS ONLY PAYABLE IN CONJUNCTION WITH 75557, 75559, 75561, OR 75563 (SAME DATE OF SERVICE). |
| 5318 | CLAIM DENIED. 88388 IS ONLY PAYABLE IN CONJUNCTION WITH 88329 THROUGH 88334 (SAME DATE OF SERVICE). |
| 5319 | CLAIM DENIED. PROCEDURE CODES A4351 AND A4352 ARE NOT PAYABLE ON THE SAME DATEOF SERVICE AS A4353. |
| 5320 | PROCEDURE CODES 99408 AND 99409 NOT PAYABLE ON SAME DATE OF SERVICE AS PROCEDURE CODE 99213. |
| 5321 | PROCEDURE CODE 99408 AND 99409 NOT ALLOWED ON THE SAME DATE OF SERVICE. |
| 5322 | PROCEDURE CODE G0390 IS PAYABLE ONLY WHEN BILLED IN CONJUNCTION WITH PROCEDURECODE 99291 ON THE SAME DATE OF SERVICE. |
| 5323 | REVENUE CODE 550 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155 OR 159. |
| 5324 | PROCEDURE CODE 99417 MUST BE BILLED IN CONJUNCTION WITH 99205, 99215, 99245, 99345, 99350 OR 99483. |
| 5325 | CCBHC CLAIMS REQUIRE T1040 PLUS AT LEAST ONE OTHER COVERED SERVICE. |
| 5326 | RENTAL OF PROCEDURE CODE E0560 ALLOWED ONLY IF RENTAL OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR THE SAME DATE OF SERVICE. |
| 5327 | V5171, V5172, AND V5181 ONLY PAYABLE IF DATE OF SERVICE IS WITHIN 5 YEARS OF CERTAIN PREVIOUSLY PAID HEARING AID CODES. |
| 5328 | PURCHASE OF PROCEDURE CODE E0560 ALLOWED ONLY IF PURCHASE OF PROCEDURE CODE E0601 IS PAID IN HISTORY FOR SAME DATE OF SERVICE. |
| 5329 | RENTAL OF PROCEDURE CODE E0560 AND E0562 NOT ALLOWED IN THE SAME MONTH. |
| 5330 | THE PREOPERATIVE AND/OR POSTOPERATIVE MANAGEMENT CARE HAS ALREADY BEEN PAID TO ANOTHER PROVIDER. |
| 5331 | DETAIL DENIED. PROCEDURE CODE HAS BEEN PAID IN FULL OR PARTIALLY PAID TO ANOTHER SURGEON. |
| 5332 | PREOPERATIVE OR POSTOPERATIVE MANAGEMENT NOT ALLOWED IF SURGICAL CARE HAS NOT BEEN PAID IN HISTORY. |
| 5333 | CLAIM/DETAIL DENIED. PROCEDURE CODE 99417 IS NOT PAYABLE WHEN BILLED IN CONJUCTION WITH MONITORED PROCEDURE CODES AND VICE VERSA. |
| 5334 | DETAIL DENIED. THE SURGEON'S CLAIM, FOR THE SAME PROCEDURE CODE, SAME MEMBER, SAME DOS, NOT FOUND IN HISTORY. |
| 5335 | DETAIL DENIED. RADIOLOGY PROCEDURE CODE NOT ALLOWED FOR SAME DOS, SAME MEMBER AS TECHNICAL COMPONENT FOR SAME PROCEDURE CODE. |
| 5336 | DETAIL DENIED. TECHNICAL COMPONENT INCLUDED IN THE GLOBAL PAYMENT FOR THE SAMERADIOLOGY PROCEDURE, ON SAME DOS, SAME MEMBER. |
| 5337 | DETAIL DENIED. RADIOLOGY TECHNICAL COMPONENT OR PROFESSIONAL COMPONENT NOT ALLOWED SAME DATE OF SERVICE AS SAME TECHNICAL COMPONENT OR PROFESSIONAL COMPONENT |
| 5338 | DETAIL DENIED. SAME GLOBAL RADIOLOGY PROCEDURE CODE NOT ALLOWED FOR THE SAME DOS, SAME MEMBER. |
| 5400 | MILEAGE, OXYGEN AND SUPPLIES PROC CODE MUST MATCH. |
| 5417 | FLUORIDE MUST BE BILLED IN CONJUSTION WITH PROPHY |
| 5418 | PROCEDURE CODE A4264 MUST BE BILLED WITH PROCEDURE CODE 58565. |
| 5421 | 99292 MUST BE BILLED IN CONJUNCTION WITH 99291. |
| 5422 | PERI AND ROOT SCALING NOT ALLOWED SDOS AS PROPHY |
| 5423 | E AND M CODE MUST BE BILLED WITH PROCEDURE CODE 90832, 90834 OR 90837. |
| 5424 | PROCEDURE CODE 90785 MUST BE BILLED WITH ONE OF THE PSYCHIATRIC DIAGNOSTIC PROCEDURE CODES. |
| 5425 | PROCEDURE CODES 90833, 90836 AND 90838 MUST BE BILLED WITH PROCEDURE CODES IN RANGE 99201 THRU 99255, 99304 THRU 99337 OR 99341 THRU 99350. |
| 5426 | PROCEDURE CODE 90840 MUST BE BILLED WITH PROCEDURE CODE 90839. |
| 5427 | PROCEDURE CODE 99050 MUST BE BILLED WITH AN EVALUATION AND MANAGEMENT PROCEDURECODE. |
| 5428 | PROCEDURE CODE 90785 MUST BE BILLED WITH ONE OF THE PSYCHIATRIC DIAGNOSTIC PROCEDURE CODES. |
| 5431 | PROCEDURE CODE 99401 WITH MODIFIER CR LIMITED TO ONE PER DOS. |
| 5500 | STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG |
| 5510 | DUPLICATE CLAIM DPH AND OTHER PROVIDER |
| 5512 | CLAIM/DETAIL DENIED. OFFICE VISITS NOT PAYABLE ON THE SAME DATE OF SERVICE AS CONSULTATIONS. |
| 5513 | CLAIM/DETAIL DENIED. MEMBERS ARE ALLOWED EITHER GLASSES OR CONTACTS WITHIN A YEAR, NOT BOTH. |
| 5516 | SERVICES FOR THIS MEMBER ARE NOT PAYABLE TO TWO DIFFERENT CCBHC PROVIDERS FOR THE SAME DATE OF SERVICE NOR ARE THEY PAYABLE TO A CCBHC AND A CMHC PROVIDER FOR |
| 5517 | PROCEDURE CODE A0425 MUST BE BILLED WITH PROCEDURE CODE A0428. |
| 5518 | PROCEDURE CODES A0425/A0428 ARE LIMITED TO $2,500.00 PER YEAR. |
| 5607 | DETAIL DENIED. PROCEDURE CODE PAID TO ANOTHER PROVIDER FOR THE SAME DATE OF SERVICE. |
| 5632 | LAP HYSTER NOT BILLABLE WITH OTHER HYSTER PROC |
| 5649 | LAB CODE ALREADY PAID FOR DOS BILLED. |
| 5700 | CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID NCCI COLUMN 2 PROCEDURE CODE. TO BE PAID FORT |
| 5701 | CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 PROCEDURE CODE. THIS DENIED SERVICE SHOULD NOT |
| 5702 | CLAIM/DETAIL DENIED. THIS NCCI COLUMN 1 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID NCCI COLUMN 2 PROCEDURE CODE. TO BE PAID FORT |
| 5703 | CLAIM/DETAIL DENIED. THIS NCCI COLUMN 2 PROCEDURE CODE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO AN NCCI COLUMN 1 PROCEDURE CODE. THIS DENIED SERVICE SHOULD NOT |
| 6055 | LIMITATION OF 26 VISITS PER CALENDAR YEAR EXCEEDED. |
| 6099 | CLAIM DENIED. LIMIT OF 25 NDCS PER DETAIL EXCEEDED. |
| 6189 | CLAIM/DETAIL DENIED. 99407 IS LIMITED TO 2 UNITS PER CALENDAR YEAR, PER MEMBER. |
| 6200 | MEMBERS ARE LIMITED TO ONE (1) OPTHAMOLOGICAL EXAMINATION PER PROVIDER PER CALENDAR YEAR. |
| 6205 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER MEMBER PER PROVIDER, PER CALENDAR YEAR. |
| 6210 | PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99348. |
| 6211 | PROCEDURE CODES 99349 AND 99350 ARE LIMITED TO ONE UNIT PER CALENDAR YEAR, PER PROVIDER. |
| 6217 | CARDIOVASCULAR DEVICE EVALUATION CODE LIMITED TO ONE IN A 90 DAY TIME PERIOD. |
| 6218 | INTERROGATION DEVICE EVALUATION CODE LIMITED TO ONE IN A 30 DAY TIME PERIOD. |
| 6220 | CERTAIN MICHELLE P. WAIVER SERVICES ARE LIMITED TO 40 HOURS CUMMULATIVELY PER CALENDAR WEEK. |
| 6232 | PROCEDURE CODE A7048 IS LIMITED TO ONE PER CALENDAR MONTH PER MEMBER. |
| 6234 | PROCEDURE CODE H0031 IS LIMITED TO 40 UNITS (10 HOURS) PER STATE FISCAL YEAR. |
| 6235 | PROCEDURE CODE H0032 IS LIMITED TO 16 UNITS (4 HOURS) PER WEEK. |
| 6236 | DETAIL DENIED. PROCEDURE CODE IS LIMITED TO TWO EVERY 24 MONTHS. |
| 6237 | PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH. |
| 6238 | HOME DELIVERED MEALS ARE LIMITED TO ONE PER DAY, PER MEMBER. |
| 6239 | HOME DELIVERED MEALS ARE LIMITED TO 5 UNITS PER CALENDAR WEEK, PER MEMBER. |
| 6257 | PROCEDURE CODE S5100 IS LIMITED TO 200 UNITS PER CALENDAR WEEK PER MEMBER. |
| 6258 | DETAIL DENIED. ADULT DAY HEALTH AND/OR HOME AND COMMUNITY SUPPORTS SERVICES LIMITED TO $200 PER DAY PER MEMBER. |
| 6259 | PROCEDURE CODE T1016 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. |
| 6262 | PROCEDURE CODE 99188 IS LIMITED TO 2 UNITS PER CALENDAR YEAR. |
| 6263 | REVENUE CODE 590 IS LIMITED TO ONE PER CALENDAR MONTH, PER MEMBER. |
| 6264 | PROCEDURE CODE T2040, MODIFIER HI, IS LIMITED TO TWO UNITS PER CALENDAR MONTH, PER MEMBER. |

| EOB Code | Description |
|---|---|
| 6265 | TOTAL AMOUNT ALLOWED FOR ENVIRONMENTAL AND MINOR HOME ADAPTATION HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. |
| 6266 | TOTAL AMOUNT ALLOWED FOR GOODS AND SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVEL OF CARE YEAR. |
| 6267 | DETAIL DENIED. EXCEEDS THE $200 ALLOWED PER DOS FOR RESPITE SERVICES PER MEMBER. |
| 6285 | TOTAL AMOUNT ALLOWED FOR RESPITE SERVICES HAS BEEN EXCEEDED FOR MEMBER'S LEVELOF CARE YEAR. |
| 6289 | DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. |
| 6304 | DETAIL DENIED. RESPITE SERVICE ARE LIMITED TO $4000.00 PER CALENDAR YEAR. |
| 6305 | ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO $500.00 PER CALENDAR PER MEMBER. |
| 6306 | FINANCIAL MANAGEMENT IS LIMITED TO 8 UNITS PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. |
| 6307 | DENTAL PROCEDURE CODE D7960 IS LIMITED TO TWO UNITS PER DATE OF SERVICE PER MEMBER. |
| 6308 | COMMUNITY LIVING SUPPORTS IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. |
| 6309 | ADULT DAY TRAINING AND SUPPORTED EMPLOYMENT ARE LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. |
| 6310 | NURSING SUPPORTS SERVICES ARE LIMITED TO 28 UNITS PER CALENDAR WEEK FOR ABI LTCMEMBERS. |
| 6318 | ENVIRONMENT AND MINOR HOME ADAPTATION ARE LIMITED TO $2000.00 PER CALENDAR YEARFOR MEMBERS IN THE ABI LTC WAIVER PROGRAM. |
| 6319 | FAMILY TRAINING IS LIMITED TO 8 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. |
| 6320 | THIS PROCEDURE IS LIMITED TO 16 UNITS PER DAY. |
| 6321 | PROCEDURE CODES T2033 AND S5136 ARE LIMITED TO ONE UNIT PER DAY FOR ABI LTC MEMBERS. |
| 6323 | OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS. |
| 6324 | SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS. |
| 6325 | PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR ABI LTC MEMBERS. |
| 6326 | RESPITE SERVICES ARE LIMITED TO 1,440 HOURS PER MEMBER, PER CALENDAR YEAR FOR ABI LTC MEMBERS. |
| 6327 | ADULT DAY HEALTH CARE IS LIMITED TO 160 UNITS PER CALENDAR WEEK FOR ABI LTC MEMBERS. |
| 6328 | CLAIM/DETAIL DENIED. PROCEDURE(S) LIMITED TO FOUR UNITS PER DATE OF SERVICE. |
| 6329 | PROCEDURE CODE D1208 IS LIMITED TO TWO UNITS PER YEAR. |
| 6330 | THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER. |
| 6331 | THIS PROCEDURE IS LIMITED TO ONE PER LIFETIME, PER MEMBER, PER LOWER QUADRANT. |
| 6332 | DENTAL PROCEDURE CODE D1208 IS LIMITED TO TWO PER YEAR PER MEMBER. |
| 6333 | CLAIM DENIED. PROCEDURE CODES 64492 AND 64495 ARE EACH LIMITED TO ONE UNIT PERDAY. |
| 6334 | CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO 336 HOURS PER MEMBER, PERPROVIDER, PER 12 MONTHS. |
| 6335 | CLAIM/DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO $2000.00 PER MEMBER, PER PROVIDER, PER 12 MONTHS. |
| 6336 | CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SUPERVISED RESIDENTIAL CARE IS PAYABLE PER DAY, PER MEMBER, PER PROVIDER. |
| 6337 | CLAIM DETAIL DENIED OR PAYMENT REDUCED. RESPITE IS LIMITED TO $4000.00 PER 365DAYS FOR THIS MEMBER. |
| 6338 | ONLY ONE UNIT OF RESIDENTIAL SERVICES CAN BE BILLED PER DAY PER PROVIDER FOR ANSCL2 MEMBER. |
| 6339 | CERTAIN SCL2 SERVICES ARE LIMITED TO 64 UNITS CUMULATIVELY PER DAY FOR SCL2 MEMBERS. |
| 6340 | DAY TRAINING CANNOT BE BILLED MORE THAN 5 DAYS DURING A CALENDAR WEEK FOR AN SCL2 MEMBER. |
| 6341 | OCCUPATIONAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER. |
| 6342 | SPEECH THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER. |
| 6343 | PHYSICAL THERAPY IS LIMITED TO 52 UNITS PER CALENDAR MONTH FOR AN SCL2 MEMBER. |
| 6344 | DAY TRAINING AND SUPPORTED EMPLOYMENT LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEK FOR AN SCL2 MEMBER. |
| 6345 | COMMUNITY ACCESS SERVICES ARE LIMITED TO 160 CUMULATIVE UNITS PER CALENDAR WEEKFOR SCL2 MEMBERS. |
| 6346 | TRANSPORTATION NON-RESIDENTIAL SERVICES ARE LIMITED TO $265.00 PER CALENDAR MONTH FOR AN SCL2 MEMBER. |
| 6347 | SHARED LIVING SERVICES ARE LIMITED TO $600.00 PER CALENDAR MONTH FOR SCL2 MEMBERS. |
| 6348 | VEHICLE ADAPTATION SERVICES ARE LIMITED TO $6000.00 PER 5 YEARS FOR AN SCL2 MEMBER. |
| 6349 | ENVIRONMENTAL ACCESSIBILITY SERVICES LIMITED TO $8000.00 FOR THIS TIME PERIOD. |
| 6350 | T1005 IS LIMITED TO 3,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD. |
| 6351 | T1999 IS LIMITED TO $1800.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD. |
| 6352 | H0023 IS LIMITED TO 1,320 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CAREPERIOD. |
| 6353 | H0004 IS LIMITED TO 160 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD. |
| 6354 | H2015 IS LIMITED TO 576 UNITS OF SERVICE DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD. |
| 6355 | PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 4 HOURS PER DAY PER MEMBER. |
| 6356 | PROCEDURE CODES 90832, 90834, 90835, 90887 AND H0004 ARE LIMITED CUMULATIVELY TO 16 HOURS PER CALENDAR WEEK PER MEMBER. |
| 6357 | PROCEDURE CODE T1023 IS LIMITED TO 5 UNITS PER CALENDAR MONTH PER MEMBER. |
| 6358 | PROCEDURE CODE 90853 IS LIMITED TO 12 UNITS PER DAY PER MEMBER. |
| 6359 | PROCEDURE CODE 90853 IS LIMITED TO 36 UNITS PER CALENDAR WEEK PER MEMBER. |
| 6360 | PROCEDURE CODE T2023 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER. |
| 6361 | PROCEDURE CODE T2012 IS LIMITED TO 7 HOURS PER DAY PER MEMBER. |
| 6362 | PROCEDURE CODE S9480 IS LIMITED TO 3 HOURS PER DAY PER MEMBER. |
| 6363 | PROCEDURE CODE S9480 IS LIMITED TO 15 HOURS PER CALENDAR WEEK PER MEMBER. |
| 6364 | PROCEDURE CODE H2019, MODIFIER UG, IS LIMITED TO 16 UNITS PER DAY PER MEMBER. |
| 6365 | PROCEDURE CODE H2019, EXCLUDING MODIFIER UG, IS LIMITED TO 24 UNITS/DAY PER MEMBER. |
| 6366 | PROCEDURE CODE S9485 IS LIMITED TO TEN CONSECUTIVE DAYS. |
| 6367 | PROCEDURE CODE H2021, MODIFIERS HM, HN & HS, IS LIMITED CUMULATIVELY TO 16 UNITS/DAY. |
| 6368 | PROCEDURE CODE S5145 IS LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER. |
| 6370 | T2025 IS LIMITED TO $1,000.00 DURING AN SCL2 MEMBER'S PLAN OF CARE PERIOD. |
| 6371 | NEW PATIENT DOMICIARY, REST HOME, AND CUSTODIAL CARE SERVICES ARE LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS. |
| 6377 | PROCEDURE CODE 83655, MODIFIERS 33 AND U7, IS LIMITED TO ONE PER CALENDAR YEAR,PER MEMBER. |
| 6378 | MEMBERS 0 THRU 15 MONTHS OF AGE ALLOWED SIX EPSDT/WELL CHILD VISIT PROCEDURES WHEN BILLED WITH MODIFIERS 33 AND UA. |
| 6379 | CERVICAL CANCER SCREENING IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. |
| 6380 | PROCEDURE CODE S9485 LIMITED TO ONE PER DAY, PER MEMBER. |
| 6381 | PROCEDURE CODE A6545 IS LIMITED TO TWO PER LEG PER MEMBER PER CALENDAR YEAR. |
| 6383 | ONE COLON CANCER SCREENING PROCEDURE ALLOWED WHEN BILLED WITH MODIFIERS 33 AND U7 PER CALENDAR YEAR, PER MEMBER. |
| 6384 | SPIROMETRY TESTING FOR ASSESSMENT AND DIAGNOSIS OF COPD IS LIMITED TO 1 PER CALENDAR YEAR, PER MEMBER. |
| 6385 | PROCEDURE CODE A5057 IS LIMITED TO 31 UNITS PER CALENDAR MONTH PER MEMBER. PRIOR AUTHORIZATION REQUIRED FOR UNITS EXCEEDING 31. |
| 6386 | ONE NUTRITION AND ONE PHYSICAL ACTIVITY COUNSELING PROCEDURE ALLOWED PER MEMBER, PER CALENDAR YEAR. |
| 6387 | PROCEDURE FOR CONTROLLING BLOOD PRESSURE IS LIMITED TO ONE PER CALENDAR YEAR, PER MEMBER. |
| 6388 | PROCEDURE CODE S8189 IS LIMITED TO TWO PER CALENDAR MONTH PER MEMBER. |
| 6390 | PROCEDURE CODE D1354 IS LIMITED TO 2 UNITS PER 6 CALENDAR MONTHS. |
| 6391 | PROCEDURE CODE D1354 IS LIMITED TO 2 UNITS PER QUADRANT PER MEMBER PER CALENDARYEAR. |
| 6392 | SERVICES ARE LIMITED TO 40 HOURS PER CALENDAR WEEK FOR MEMBERS IN THE MICHELLEPWAIVER PROGRAM. |
| 6393 | PROCEDURE CODE D1354 IS LIMITED TO TWO UNITS PER TOOTH PER MEMBER PER SIX MONTHS. |
| 6394 | PROCEDURE CODE A9276 IS LIMITED TO 31 UNITS PER MEMBER PER CALENDAR MONTH. |

| EOB Code | Description |
|---|---|
| 6395 | PROCEDURE CODE A9278 IS LIMITED TO ONE UNIT PER MEMBER PER CALENDAR YEAR. |
| 6396 | PROCEDURE CODE A9277 IS LIMITED TO TWO UNITS PER MEMBER PER CALENDAR YEAR. |
| 6397 | PROCEDURE CODES D9222 AND D9223 ARE LIMITED CUMULATIVELY TO FOUR (4) UNITS PER DATE OF SERVICE, PER MEMBER. |
| 6398 | PROCEDURE CODE A4224 IS LIMITED TO FIVE UNITS PER CALENDAR MONTH PER MEMBER. |
| 6399 | PROCEDURE CODE A4225 IS LIMITED TO FIFTEEN UNITS PER CALENDAR MONTH PER MEMBER. |
| 6401 | THIS SERVICE IS LIMITED TO 6 UNITS PER SIX MONTHS. |
| 6402 | VACCIN CO UN SELING PROCEDURE CODE 99401 IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER DATE OF SERVICE. |
| 6403 | VACCINE COUNSELING PROCEDURE CODE 99401 IS LIMITED TO 4 PER MEMBER PER YEAR. |
| 6407 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6408 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6409 | SHARED LIVING SERVICES ARE LIMITED TO $660.00 PER CALENDAR MONTH FOR SCL2 MEMBERS. |
| 6410 | SHARED LIVING SERVICES ARE LIMITED TO $726.00 PER CALENDAR MONTH FOR SCL2 MEMBERS. |
| 6411 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6412 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6413 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6414 | PROCEDURE CODE IS LIMITED TO 2 UNITS, PER MEMBER, PER CALENDAR WEEK. |
| 6415 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6416 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6417 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6418 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6419 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6420 | PROCEDURE CODE IS LIMITED TO 104 UNITS, PER MEMBER, PER CALENDAR YEAR. |
| 6514 | HOME HEALTH LIMITS EXCEEDED FOR 1 MONTH |
| 6515 | PROCEDURE CODE D9248 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. |
| 6516 | OCCUPATIONAL THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6517 | PHYSICAL THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6518 | SPEECH THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6519 | OCCUPATIONAL THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6520 | PHYSICAL THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6521 | SPEECH THERAPY SERVICES EXCEED THE 30 VISITS ALLOWED PER CALENDAR YEAR PER MEMBER. PRIOR AUTHORIZATION REQUIRED. |
| 6522 | PROCEDURE CODE 87529 IS LIMITED TO TWO (2) UNITS PER DAY PER MEMBER. |
| 6523 | PROCEDURE CODES E0443 AND E0444 ARE LIMITED CUMULATIVELY TO ONE UNIT PER MONTH,PER MEMBER. |
| 6524 | PROCEDURE CODE A9274 IS LIMITED TO 12 UNITS PER CALENDAR MONTH, PER MEMBER. |
| 6525 | REVENUE CODE 905 IS LIMITED TO ONE UNIT PER DAY, PER MEMBER. |
| 6526 | PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. |
| 6527 | MAXIMUM DOSAGES ALLOWED FOR PROCEDURE CODE S0190 PER DAY PER MEMBER HAS BEEN EXCEEDED. |
| 6528 | PROCEDURE CODE H2019 IS LIMITED TO 12 UNITS (3 HOURS) PER DAY PER MEMBER. |
| 6529 | PROCEDURE CODE J2350 IS LIMITED TO 600 UNITS/MGS PER DAY PER MEMBER. |
| 6530 | PROCEDURE CODE IS LIMITED TO ONE UNIT PER MEMBER IN A 365 DAY TIME PERIOD. |
| 6531 | PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 49 DAY TIME PERIOD. |
| 6532 | PROCEDURE CODE 90868 IS LIMITED TO 36 UNITS PER MEMBER IN A 365 DAY TIME PERIOD. |
| 6533 | H0038HQ LIMITED TO 8 UNITS PER DATE OF SERVICE PER MEMBER PER PROVIDER. |
| 6536 | PROCEDURE CODE A9277 IS LIMITED TO FOUR UNITS PER MEMBER PER CALENDAR YEAR. |
| 6538 | HOSPITAL RESERVE DAYS LIMITED TO 30 PER MEMBER PER CALENDAR YEAR. |
| 6539 | PROCEDURE CODE IS LIMITED TO ONE PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. |
| 6540 | PROCEDURE CODE IS LIMITED TO $6000.00 PER MEMBER IN A 5 CALENDAR YEARS TIME PERIOD. |
| 6541 | DENTAL PROCEDURE CODES D7961 AND D7962 ARE LIMITED CUMULATIVELY TO 4 UNITS PER DATE OF SERVICE, PER MEMBER. |
| 6542 | PURCHASE OF PROCEDURE CODE E0329 LIMITED TO ONE PER 5 CALENDAR YEARS, PER MEMBER. |
| 6543 | CLAIM/DETAIL DENIED. MONITORED PROCEDURE CODES ARE LIMITED TO ONE PER MEMBER, PER 5 YEARS. |
| 6544 | CLAIM/DETAIL DENIED. MONITORED PROCEDURE CODES ARE LIMITED TO ON PER MEMBER, PER 4 YEARS. |
| 6545 | CLAIM/DETAIL DENIED. MONITORED DENTAL PROCEDURE CODES ARE LIMITED TO ONE PER MEMBER, PER 2 YEARS. |
| 6547 | MEMBER IS LIMITED TO ONE HUMIDIFIER PURCHASE IN A TWO-YEAR TIME PERIOD. |
| 6548 | DETAIL DENIED BY DMS AFTER REVIEW OF SUBMITTED DOCUMENTATION. |
| 6549 | PROCEDURE CODE B4100 IS LIMITED TO 180 UNITS (OUNCES) PER CALENDAR MONTH UNLESSPA IS ON FILE FOR ADDITIONAL SERVICES. |
| 6553 | PROCEDURE CODE IS LIMITED TO 192 UNITS PER CALENDAR MONTH, PER MEMBER. |
| 6554 | WAIVER LIMIT FOR PHARMACY HAS BEEN REACHED |
| 6555 | COVID-19 IS LIMITED TO ONE PER DAY PER MEMBER. |
| 6556 | HEARING EVALUATION PROCEDURE CODE IS LIMITED TO 4 PER MEMBER PER CALENDAR YEAR. |
| 6557 | HEARING EVALUATION PROCEDURE CODE IS LIMITED TO 1 PER MEMBER PER CALENDAR YEAR |
| 6558 | HEARING FOLLOW UP PROCEDURE CODES LIMITED TO 1 PER MEMBER PER CALENDAR YEAR. |
| 6559 | HOME INFUSION THERAPY PROCEDURE CODES LIMITED TO ONE PER MEMBER PER DATE OF SERVICE. |
| 6560 | CLAIM/DETAIL DENIED. PROCEDURE CODE 92015 IS LIMITED TO ONE PER MEMBER PER YEAR. |
| 6561 | CLAIM/DETAIL DENIED. REPAIR AND REFITTING OF SPECTACLES IS LIMITED TO TWO PER MEMBER PER YEAR. |
| 6562 | CLAIM/DETAIL DENIED. ESTABLISHED OFFICE VISIT LIMITED TO TWO PER MEMBER PER PROVIDER, PER YEAR. |
| 6565 | CLAIM/DETAIL DENIED. EAR IMPRESSIONS LIMITED TO 6 PER CALENDAR YEAR, PER EAR |
| 6566 | CLAIM/DETAIL DENIED. HEARING AID BATTERIES LIMITED TO 12 PER CALENDAR YEAR, PEREAR. |
| 6568 | PROCEDURE CODE IS LIMITED TO TWO PER TOOTH PER LIFETIME |
| 6569 | D9110 ON SAME DOS AS OTHER PROCEDURE |
| 6570 | PROCEDURE CODE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 12 MONTHS |
| 6571 | PROCEDURE CODE IS LIMITED TO ONE PER 12 MONTHS. |
| 6572 | PROCEDURE CODE IS LIMITED TO ONE PER 2 YEARS |
| 6573 | PROCEDURE CODE IS LIMITED TO ONE PER QUADRANT PER 36 MONTHS |
| 6574 | PROCEDURE CODE IS LIMITED TO ONE PER TOOTH PER 5 YEARS |
| 6575 | PROCEDURE CODE IS LIMITED TO ONE PER 5 YEARS |
| 6576 | PROCEDURE IS LIMITED TO ONE PER 5 YEARS |
| 6577 | PROCEDURE IS LIMITED TO ONE PER 6 MONTHS PER MEMBER |
| 6578 | PROCEDURE IS LIMITED TO ONE PER AREA (TOOTH) PER LIFETIME |
| 6579 | PROCEDURE IS LIMITED TO ONE PER TOOTH PER LIFETIME |
| 6580 | PROCEDURE IS LIMITED TO ONE PER SITE (QUADRANT) PER LIFETIME |
| 6581 | PROCEDURE IS LIMITED TO ONE PER TOOTH, PER QUADRANT, PER LIFETIME |

| EOB Code | Description |
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| 6582 | PROCEDURE IS LIMITED TO ONE PER 5 YEARS UNLESS PA IS ON FILE FOR ANY ADDITIONALSERVICES THAT ARE DEEMED MEDICALLY NECESSARY |
| 6584 | PROCEDURE IS LIMITED TO ONCE EVERY 5 YEARS |
| 6585 | PROCEDURE IS LIMITED TO TWO PER MEMBER PER 12 MONTHS |
| 6586 | PROCEDURE IS LIMITED TO ONE SET PER MEMBER, PER PROVIDER PER 12 MONTHS |
| 6587 | PROCEDURE CODE IS LIMITED TO 180 UNITS PER CALENDAR MONTH, PER MEMBER. |
| 6588 | PROCEDURE CODE IS LIMITED TO 150 UNITS PER CALENDAR MONTH, PER MEMBER. |
| 6589 | PROCEDURE IS NOT TO EXCEED THREE REPAIRS PER 12 MONTHS |
| 6590 | PROCEDURE IS LIMITED TO ONCE PER TOOTH, PER MEMBER, PER 12 MONTHS |
| 6591 | PROCEDURE IS LIMITED TO ONE PER 6 MONTHS |
| 6592 | CLAIM/DETAIL DENIED. D0120 IS LIMITED TO ONE PER 6 MONTHS. |
| 6593 | PROCEDURE IS LIMITED TO ONE PER 6 MONTHS, PER MEMBER, PER PROVIDER |
| 6594 | PROCEDURE IS LIMITED TO ONE PER 12 MONTHS |
| 6598 | CLAIM/DETAIL DENIED. PROCEDURE CODE E0483 IS LIMITED TO 3 CONSECUTIVE MONTHS RENTAL. |
| 6600 | CLAIM/DETAIL DENIED. E0483 IS LIMITED TO 3 MONTHS OF RENTAL PER 12 MONTH PERIOD. |
| 6602 | PROCEDURE CODE IS LIMITED TO 6 UNITS PER CALENDAR YEAR, PER MEMBER. |
| 6603 | PROCEDURE CODE IS LIMITED TO 2 UNITS PER CALENDAR MONTH, PER MEMBER |
| 6604 | PROCEDURE CODE E0271 IS LIMITED TO 1 PER MEMBER, PER CALENDAR YEAR. |
| 6605 | PROCEDURE IS LIMITED TO 2 PER CALENDAR YEAR UNLESS PA IS ON FILE FOR ANY ADDITIONAL SERVICES THAT ARE DEEMED MEDICALLY NECESSARY. |
| 6606 | CLAIM/DETAIL DENIED. HEARING AID BATTERIES LIMITED TO 12 PER CALENDAR MONTH, PER EAR. |
| 6608 | PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH, UNLESS PRIOR AUTHORIZATIONIS ON FILE. |
| 6609 | WHEN THE SAME PROCEDURE IS BILLED WITH MODIFERS LT AND RT, REIMBURSEMENT FOR ONE UNIT IS 100% OF RATE ALLOWED AND ONE UNIT WILL BE REIMBURSED AT 50% OF THE RA |
| 6610 | A SPEECH THERAPY SERVICE HAS ALREADY BEEN PAID FOR THE DOS. SUBSEQUENT SPEECHTHERAPY SERVICES BILLED FOR THE SAME DOS ARE PAID ZERO. |
| 6611 | AN OCCUPATIONAL THERAPY SERVICE HAS ALREADY BEEN PAID FOR THE DOS. SUBSEQUENT OCCUPATIONAL THERAPY SERVICES BILLED FOR THE SAME DOS ARE PAID ZERO. |
| 6612 | A PHYSICAL THERAPY SERVICE HAS ALREADY BEEN PAID FOR THE DOS. SUBSEQUENT PHYSICAL THERAPY SERVICES BILLED FOR THE SAME DOS ARE PAID ZERO. |
| 6613 | PROCEDURE CODE S5170 LIMITED TO 2 PER DAY, PER MEMBER. |
| 6614 | PROCEDURE CODE T2022 IS LIMITED TO 1 UNIT OF SERVICE PER MONTH. |
| 6615 | PROCEDURE CODE T2022 IS LIMITED TO 1 ADDITIONAL UNIT PER PLAN OF CARE YEAR. |
| 6616 | PROCEDURE CODE H0004 IS LIMITED TO 160 UNITS OF SERVICE PER PLAN OF CARE YEAR. |
| 6617 | PROCEDURE CODE H0004 IS LIMITED TO 80 ADDITIONAL UNITS OF SERVICE PER PLAN OF CARE YEAR. |
| 6618 | PROCEDURE CODE E1399 IS LIMITED TO LIFETIME LIMIT $9,680.00. |
| 6619 | PROCEDURE CODE T1016 IS LIMITED TO 1 UNIT OF SERVICE PER DAY. |
| 6620 | PROCEDURE CODE IS LIMITED TO A MAXIMUM OF $825.00 PER DAY. |
| 6621 | PROCEDURE CODE 97535 IS LIMITED TO 16 HOURS OF SERVICE PER DAY. |
| 6623 | PROCEDURE CODE 97535 IS LIMITED TO 20 HOURS OF SERVICE PER CALENDAR WEEK. |
| 6624 | PROCEDURE CODE T1005 IS LIMITED TO 830 HOURS PER PLAN OF CARE YEAR. |
| 6625 | PROCEDURE CODE T1005 WITH MODIFIER U9 IS LIMITED TO 830 HOURS PER PLAN OF CAREYEAR. |
| 6626 | PROCEDURE CODE T1005 IS LIMITED TO 70 ADDITIONAL HOURS PER PLAN OF CARE YEAR. |
| 6627 | PROCEDURE CODE T1005 WITH MODIFIER U9 IS LIMITED TO 70 ADDITIONAL SERVICE UNITSPER PLAN OF CARE YEAR. |
| 6628 | DETAIL DENIED. ONLY ONE SPEECH THERAPY EVALUATION IS ALLOWED PER DATE OF SERVICE, PER MEMBER. |
| 6629 | DETAIL DENIED. ONLY ONE OCCUPATIONAL THERAPY EVALUATION IS ALLOWED PER DATE OFSERVICE, PER MEMBER. |
| 6630 | DETAIL DENIED. ONLY ONE PHYSICAL THERAPY EVALUATION IS ALLOWED PER DATE OF SERVICE, PER MEMBER. |
| 6631 | MAXIMUM OF 60 CONSECUTIVE DAYS ALLOWED PER MEMBER PER INPATIENT STAY. |
| 6660 | THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED. |
| 6661 | PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMPREHENSIVE SERVICE HAS BEEN PAID. |
| 6700 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE |
| 6701 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE |
| 6702 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE |
| 6703 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 60 DAYS OF SURGICAL PROCEDURE |
| 6704 | FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE |
| 6726 | DENTAL PROPHY/FLUORIDE LIMITED TO 2 PER 351 DAYS |
| 6737 | CLAIM/DETAIL PAYMENT REDUCED. HEARING AIDS ARE LIMITED TO $800.00 PER EAR |
| 6742 | PROCEDURE CODE D1206 IS LIMITED TO ONE UNIT PER 90 DAYS. |
| 6743 | PROCEDURE CODE D1206 IS LIMITED TO TWO UNITS PER YEAR. |
| 6744 | THIS SERVICE IS LIMITED TO 64 UNITS PER DAY OR IN COMBINATION WITH OTHER SELECTED PROCEDURE CODES |
| 6745 | CLAIM DENIED. MEMBER LIMITED TO 2 DIAGNOSTIC ULTRASOUNDS PER 9 MONTHS. MEDICALNECESSITY MUST SUPPORT UNUSUAL CIRCUMSTANCES. DIAGNOSIS CODE MUST INDICATE MEDIC |
| 6746 | THIS PROCEDURE LIMITED TO 1 PER MEMBER PER FOUR YRS |
| 6748 | DENTAL VISITS ARE LIMITED TO 12 PER CALENDAR YEAR FOR MEMBERS 21 YEARS OF AGE AND OLDER (PER PROVIDER). |
| 6749 | S5100 LIMITED TO 24 UNITS PER CALENDAR DAY |
| 6750 | S5100 LIMITED TO 120 UNITS PER CALENDAR WEEK |
| 6753 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99213. |
| 6754 | PROCEDURE CODE H0040 IS LIMITED TO ONE PER CALENDAR MONTH PER MEMBER. |
| 6755 | CLAIM/DETAIL DENIED. MAXIMUM OF 30 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR. |
| 6760 | MEMBER'S THERAPY SERVICES EXCEED THE 20 VISITS ALLOWED PER CALENDAR YEAR. PRIOR AUTHORIZATION REQUIRED. |
| 6764 | PROCEDURE CODE LIMITED TO 1 PER 12 MONTHS PER MEMBER, PER PROVIDER |
| 6765 | INITIAL VISIT LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS |
| 6766 | MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER. |
| 6767 | PROCEDURE CODE LIMITED 2/TOOTH/LIFETIME/MEMBER |
| 6770 | EXTRACTIONS LIMITED TO 3 PER LIFETIME PER TOOTH. |
| 6772 | DETAIL DENIED. ONLY ONE EVALUATION AND MANAGEMENT PROCEDURE CODE ALLOWED PER DATE OF SERVICE. |
| 6773 | ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO TWO PER CALENDAR YEAR. REIMBURSEMENT CUT BACK TO RATE FOR PROCEDURE CODE 99213. |
| 6774 | PURCHASE LIMITED TO 1 PER 5 YEARS |
| 6785 | PROC CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED |
| 6786 | PROC CODE MONTHLY FREQUENCY ON PA EXCEEDS |
| 6787 | REV CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED |
| 6788 | REVENUE CODE 182 IS LIMITED TO A MAXIMUM OF 15 CONSECUTIVE DAYS |
| 6789 | REVENUE CODE 189 LIMITED TO 45 DAYS PER LIFETIME |
| 6790 | PROCEDURE CODE WEEKLY FREQUENCY ON PA HAS BEEN EXCEEDED. |
| 6791 | PROCEDURE CODE MONTHLY FREQUENCY ON PA HAS BEEN EXCEEDED. |

| EOB Code | Description |
|---|---|
| 6792 | PROCEDURE CODE WEEKLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED. |
| 6793 | PROCEDURE CODE MONTHLY FREQUENCY ON PRIOR AUTHORIZATION HAS BEEN EXCEEDED. |
| 6794 | PROCEDURE CODE T1000 IS LIMITED TO NINETY-SIX (96) UNITS PER DAY, PER MEMBER, SAME OR DIFFERENT PROVIDER. |
| 6795 | PROCEDURE CODE T1000 IS LIMITED TO 8,000 UNITS (2000 HOURS) PER TWELVE (12) MONTH PERIOD, PER MEMBER, SAME OR DIFFERENT PROVIDER. |
| 6796 | PROCEDURE CODES 76700, 76705, 76770, 76775, AND G0389 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6797 | PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6798 | PROCEDURE CODES 80422, 82947-82948, 82950-82953, AND 83036 ARE LIMITED TO 1 UNIT CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6799 | PROCEDURE CODES 87590-87592, 87850, 87800, 87081, 87210, 87070, AND 87077 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6800 | PROCEDURE CODES 86701-86703, 86689, AND 87390-87391 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6801 | PROCEDURE CODES 76977, 77078-77082, 78350-78351 AND G0130 ARE LIMITED TO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6802 | REVENUE CODE 180 IS LIMITED TO 5 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS. |
| 6803 | REVENUE CODE 183 IS LIMITED TO 14 UNITS PER CALENDAR YEAR FOR PRTF AND PRTF 2 CLAIMS. |
| 6804 | THIS PROCEDURE CODE IS LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE. |
| 6805 | H0035, H0015, AND S9480 ARE LIMITED TO 1 UNIT EACH PER MEMBER, PER DATE OF SERVICE. |
| 6806 | 97003 AND 97004 NOT ALLOWED ON THE SAME DATE OF SERVICE. |
| 6807 | OCCUPATIONAL THERAPY IS LIMITED TO 20 VISITS PER MEMBER, PER CALENDAR YEAR. |
| 6808 | H0040 IS LIMITED TO 1 UNIT PER CALENDAR MONTH PER MEMBER. |
| 6809 | V2020 IS LIMITED TO ONE UNIT PER CALENDAR YEAR. |
| 6810 | EYEWARE CODES V2100 THRU V2499, V2500 THRU V2522, V2524 THRU V2531, AND V2700 THRU V2784 ARE LIMITED TO 2 UNITS (CUMULATIVELY) PER CALENDAR YEAR. |
| 6811 | T2023 LIMITED TO 1 UNIT PER CALENDAR MONTH. |
| 6812 | PROCEDURE CODE A4606 LIMITED TO 4 PER CALENDAR MONTH. |
| 6813 | PROCEDURE CODE E0602 IS LIMITED TO ONE PER CALENDAR YEAR. |
| 6814 | PROCEDURE CODES 77052, 77055, 77056, 77057, G0202, G0204, AND G0206 ARE LIMITEDTO 1 UNIT, CUMULATIVELY, PER CALENDAR YEAR, PER MEMBER. |
| 6815 | THIS PROCEDURE CODE MUST BE BILLED IN CONJUNCTION WITH 90837. |
| 6816 | 99355 IS LIMITED TO TWO UNITS PER DATE OF SERVICE, PER MEMBER. |
| 6817 | PROCEDURE CODE 99355 MUST BE BILLED IN CONJUNCTION WITH PROCEDURE CODE 99354. |
| 6818 | THIS PROCEDURE CODE IS LIMITED TO 1 UNIT OF SERVICE PER DATE OF SERVICE, PER MEMBER, PER PROVIDER. |
| 6819 | AIR AMBULANCE PROCEDURE CODES ARE ALL-INCLUSIVE AND CANNOT BE BILLED WITH OTHERPROCEDURE CODES FOR THE SAME DATE OF SERVICE. |
| 6820 | REVENUE CODES 551 AND 561 ARE LIMITED TO A TOTAL OF 16 UNITS (4 HOURS), CUMULATIVELY, PER DATE OF SERVICE, PER MEMBER. |
| 6821 | PROCEDURE CODE V2523 (CONTACT LENS) IS LIMITED TO 16 UNITS PER MEMBER, PER CALENDAR YEAR. |
| 6822 | CERTAIN PROCEDURE CODES ARE NOT PAYABLE WITHIN THE SAME CALENDAR WEEK AS H0020 OR H0047. |
| 6823 | THIS PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR WEEK. |
| 6824 | THIS PROCEDURE CODE IS LIMITED TO 4 UNITS PER CALENDAR YEAR. |
| 6825 | EYEWARE CODES V2100 THRU V2499, V2500 THRU V2522, AND V2524 THRU V2531, ARE LIMITED TO 4 UNITS (CUMULATIVELY) PER CALENDAR YEAR. |
| 6826 | LENS ADD-ON CODES LIMITED UP TO 4 EACH PER CALENDAR YEAR. |
| 6827 | PROCEDURE CODE T2022 IS LIMITED TO 1 UNIT PER MONTH. |
| 6828 | PROCEDURE CODE S9485 IS LIMITED TO ONE UNIT PER DATE OF SERVICE. |
| 6829 | PROCEDURE CODE H0018 IS LIMITED TO ONE UNIT PER DATE OF SERVICE FOR PROVIDER TYPES 26 AND 30. |
| 6830 | PROCEDURE CODE IS LIMITED TO 1 PER CALENDAR YEAR UNLESS PA IS ON FILE FOR ANY ADDITIONAL SERVICES THAT ARE DEEMED MEDICALLY NECESSARY. |
| 6831 | RESPITE SERVICES ARE LIMITED TO 5,760 UNITS PER MEMBER, PER PLAN OF CARE PERIODFOR ABI LTC MEMBERS. |
| 6832 | DETAIL DENIED. PROCEDURE CODE S5108 IS LIMITED TO 45 HOURS (180 UNITS) PER CALENDAR WEEK PER MEMBER. |
| 6833 | VEHICLE ADAPTATION SERVICES ARE LIMITED TO $7260.00 PER 5 YEARS FOR AN SCL2 MEMBER. |
| 6834 | FINANCIAL MANAGEMENT IS LIMITED TO 1 UNIT PER MEMBER, PER PROVIDER, PER CALENDAR MONTH. |
| 6835 | ENVIRONMENTAL AND MINOR HOME ADAPTATIONS ARE LIMITED TO $605.00 PER PLAN OF CARE PERIOD, PER MEMBER. |
| 6836 | HEARING AIDS ARE LIMITED TO ONE UNIT PER EAR, PER MEMBER, PER 36 MONTHS. |
| 6837 | HEARING AIDS ARE LIMITED TO ONE UNIT PER EAR, PER MEMBER, PER 36 MONTHS. |
| 6838 | PROCEDURE CODE H0034 IS LIMITED TO 182 HOURS PER YEAR |
| 6839 | PROCEDURE CODE T1005 IS LIMITED TO 21 HOURS PER MONTH. |
| 6840 | PROCEDURE CODE T1005 IS LIMITED TO 200 HOURS PER YEAR. |
| 6841 | PROCEDURE CODE IS LIMITED TO 480 UNITS PER 180 DAYS |
| 6843 | PROCEDURE CODE H0043 IS LIMITED TO 30 UNITS PER 180 DAYS. |
| 6844 | PROCEDURE CODE T2035 IS LIMITED TO $10,000.00 PER YEAR. |
| 6845 | MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE |
| 6846 | T1005 IS LIMITED TO 42 UNITS PER MEMBER, PER DATE OF SERVICE. |
| 6847 | T1005 IS LIMITED TO 1000 UNITS PER MEMBER PER PLAN OF CARE PERIOD |
| 6848 | CLAIM/DETAIL DENIED.  RESPITE SERVICES ARE LIMITED TO 5,760 UNITS PER MEMBER, PER PLAN OF CARE PERIOD. |
| 6849 | CLAIM/DETAIL DENIED.  PROCEDURE CODE 90853 IS LIMITED TO 48 UNITS PER MEMBER, PER CALENDAR MONTH. |
| 7000 | CLAIM FAILED A PRODUR ALERT |
| 7001 | CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT |
| 7002 | DENIED FOR PRODUR REASONS |
| 7020 | UNABLE TO DETERMINE THE COINS AND DED, RESUBMIT ON PAPER WITH EOMB |
| 7200 | MISCELLANEOUS CLAIMSXTEN ERROR. |
| 7201 | PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR |
| 7202 | PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS |
| 7203 | PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS |
| 7204 | PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS |
| 7205 | PROCEDURE IS NOT INDICATED FOR A MALE |
| 7206 | PROCEDURE IS NOT INDICATED FOR A FEMALE |
| 7207 | PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE |
| 7208 | PROCEDURE IS AN UNLISTED PROCEDURE |
| 7209 | PROCEDURE IS CLASSIFIED AS EXPERIMENTAL |
| 7210 | PROCEDURE IS CLASSIFIED AS OBSOLETE |
| 7211 | SUBMITTED PROCEDURE IS INVALID FOR MEMBER'S AGE. |
| 7212 | SUBMITTED PROCEDURE CODE HAS BEEN REPLACED WITH A CODE MORE APPROPRIATE FOR THEMEMBER'S AGE. |
| 7213 | SUBMITTED PROCEDURE IS INVALID FOR MEMBER'S GENDER. |
| 7214 | SUBMITTED PROCEDURE CODE HAS BEEN REPLACED WITH A CODE MORE APPROPRIATE FOR THEMEMBER'S GENDER. |
| 7215 | PROCEDURE CODE IS INCIDENTAL |
| 7216 | VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT |
| 7217 | PROCEDURE CODE HAS BEEN REBUNDLED |
| 7218 | PROCEDURE ADDED DUE TO REBUNDLING. |

| EOB Code | Description |
|---|---|
| 7219 | PROCEDURE IS MUTUALLY EXCLUSIVE |
| 7220 | PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE |
| 7221 | PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE |
| 7222 | PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON |
| 7223 | PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON |
| 7233 | DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL |
| 7234 | DENIED DUPLICATE - IS BILATERAL |
| 7235 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME |
| 7236 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY |
| 7237 | DENIED DUPLICATE (REBUNDLED) |
| 7238 | PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING |
| 7239 | PROCEDURE IS A POSSIBLE DUPLICATE |
| 7240 | SMARTSUSPENSE SUSPEND |
| 7241 | SMARTSUSPENSE DENIAL |
| 7242 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED |
| 7243 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED |
| 7244 | MEDICAL VISIT DENIED |
| 7245 | PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT |
| 7246 | PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT |
| 7247 | PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT |
| 7248 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS |
| 7249 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT |
| 7250 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT |
| 7251 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7252 | DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7253 | DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7254 | DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7255 | DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC |
| 7256 | MODIFIER 51 INVALID FOR PRIMARY PROCEDURE |
| 7257 | MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE |
| 7258 | REVIEW MODIFIER 51 |
| 7259 | SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS |
| 7260 | MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING |
| 7261 | INVALID PROCEDURE CODE |
| 7262 | DOB CANNOT BE GREATER THAN DATE OF SERVICE |
| 7263 | DOS REQUIRED FOR PROCEDURE |
| 7264 | DOS CANNOT BE A FUTURE DATE |
| 7265 | BIRTHDATE CANNOT BE A FUTURE DATE |
| 7266 | AGE CANNOT BE GREATER THAN 124 YEARS |
| 7267 | ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES |
| 7268 | PROVIDER IS REQUIRED FOR HISTORY PROCEDURES |
| 7269 | MODIFIER NOT VALID FOR THIS PROCEDURE |
| 7270 | INVALID MODIFIER/PROCEDURE CODE COMBINATION |
| 7271 | CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID |
| 7272 | DIAGNOSIS 1 MUST BE A VALID CODE |
| 7273 | DIAGNOSIS 2 MUST BE A VALID CODE |
| 7274 | DIAGNOSIS 3 MUST BE A VALID CODE |
| 7275 | DIAGNOSIS 4 MUST BE A VALID CODE |
| 7276 | DIAGNOSIS MUST BE A VALID CODE |
| 7277 | PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE |
| 7278 | INVALID DATE (DATE OF BIRTH) |
| 7279 | INVALID AMOUNT CHARGED |
| 7280 | CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED |
| 7281 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE |
| 7282 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS |
| 7283 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT |
| 7284 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT |
| 7285 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7286 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7287 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR |
| 7288 | SMARTSUSPENSE FLAG |
| 7289 | SMARTSUSPENSE MONITOR |
| 7290 | MODIFIER 51 DELETED FOR PRIMARY PROCEDURE |
| 7291 | MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE |
| 7292 | CLAIM/DETAIL DENIED. PROCEDURE IS NCCI INCIDENTAL/MUTUALLY EXCLUSIVE. |
| 7293 | CLAIM/DETAIL DENIED. PROCEDURE CODE IS CCI MUTUALLY EXCLUSIVE. |
| 7499 | MEMBER LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER |
| 7500 | YOUR CLAIM IS BEING REVIEWED |
| 7501 | YOUR CLAIM IS BEING REVIEWED. |
| 7502 | MEMBER LOCKED IN TO A SPECIFIC PROVIDER |
| 7503 | MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALERT SET ON THE CLAIM. PLEASE USE APPROPRIATE DD, LD, HD, ER, LR, PA, PG, MC, TD |
| 7504 | MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT. |
| 7505 | MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B. |
| 7506 | RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT. CONTACT COLLEGE OF PHARMACY TO RECEIVE PRIOR AUTHORIZATION. |
| 7507 | VALID OUTCOME CODE OF "NOT FILLED" RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED. |
| 7508 | Quantity dispensed on response claim same as original claim |
| 7509 | RENDERING PROVIDER ON PREPAYMENT REVIEW |
| 8000 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR. |
| 8001 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER. |

| EOB Code | Description |
|---|---|
| 8002 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE. |
| 8003 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR. |
| 8004 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY. |
| 8005 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN. |
| 8006 | PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR. |
| 8007 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR. |
| 8008 | PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC. OR UNSPECIFIED ERROR |
| 8019 | PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR. |
| 8020 | SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT. |
| 8021 | SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER. |
| 8022 | SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER. |
| 8023 | SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE |
| 8024 | SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE. |
| 8025 | SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT. |
| 8026 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE. |
| 8027 | SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE. |
| 8028 | SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE. |
| 8030 | PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR. |
| 8031 | PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE. |
| 8032 | PROVIDER REQUESTED OFFSET DUE MEDICARE. |
| 8033 | PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY. |
| 8034 | PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN. |
| 8035 | PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY. |
| 8036 | PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP |
| 8037 | PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR. |
| 8038 | PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR |
| 8039 | YOUR ADJUSTMENT REQUEST HAS RESULTED IN THE DENIAL AND RECOUPMENT OF THE CLAIM.PLEASE RESUBMIT YOUR ORIGINAL CLAIM, WITH CORRECTIONS, FOR PROCESSING. |
| 8040 | PROVIDER INITIATED INTERNET ADJUSTMENT |
| 8041 | ADJUSTMENT REQUEST DENIED. PLEASE CORRECT ERROR AND SUBMIT ANOTHER ADJUSTMENT-OR-SUBMIT ADJUSTMENT TO THE EDS ADJUSTMENT UNIT. |
| 8042 | SAVE FOR FUTURE USE. |
| 8043 | SAVE FOR FUTURE USE. |
| 8044 | SAVE FOR FUTURE USE. |
| 8045 | SAVE FOR FUTURE USE. |
| 8046 | SAVE FOR FUTURE USE. |
| 8047 | SAVE FOR FUTURE USE. |
| 8048 | SAVE FOR FUTURE USE. |
| 8049 | SAVE FOR FUTURE USE. |
| 8050 | EXPENDITURE WARRANT VOID |
| 8051 | SAVE FOR FUTURE USE. |
| 8052 | SAVE FOR FUTURE USE. |
| 8053 | SAVE FOR FUTURE USE. |
| 8054 | SAVE FOR FUTURE USE. |
| 8055 | SAVE FOR FUTURE USE. |
| 8056 | SAVE FOR FUTURE USE. |
| 8057 | SAVE FOR FUTURE USE. |
| 8058 | SAVE FOR FUTURE USE. |
| 8059 | PROVIDER SENT A FULL REFUND DUE TO COST SETTLEMENT (REQ FYE) |
| 8060 | PROVIDER SENT REFUND DUE TO BILLING ERROR. |
| 8061 | PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR. |
| 8062 | PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT. |
| 8063 | PROVIDER SENT REFUND DUE TO MEMBER/RELATIVE PAID. |
| 8064 | PROVIDER SENT REFUND DUE TO MEDICARE PAID, |
| 8065 | PROVIDER SENT REFUND DUE TO CASUALTY INSURANCE PAID. |
| 8066 | PROVIDER SENT REFUND DUE TO HEALTH INSURANCE PAID. |
| 8067 | PROVIDER SENT REFUND DUE TO SURS REVIEW. |
| 8068 | PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW. |
| 8069 | PROVIDER SENT REFUND DUE TO PAID WRONG VENDOR. |
| 8070 | PROVIDER SENT REFUND DUE TO MEDICAID FRAUD. |
| 8071 | PROVIDER SENT REFUND DUE TO MEDICAID ABUSE. |
| 8072 | PROVIDER SENT REFUND DUE TO AUTO INSURANCE PAID. |
| 8073 | PROVIDER SENT REFUND DUE TO WORKERS COMPENSATION PAID. |
| 8074 | PROVIDER SENT REFUND FOR ICN NOT IN HISTORY. |
| 8075 | PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR OTHER UNSPECIFIED ERROR. |
| 8076 | PRV REFUND - OTHER TPL REASON |
| 8077 | PRV REFUND - PSYCH CROSSOVER |
| 8079 | SAVE FOR FUTURE USE. |
| 8080 | SAVE FOR FUTURE USE. |
| 8081 | SAVE FOR FUTURE USE. |
| 8082 | NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR. |
| 8083 | NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE. |
| 8084 | NON-CLAIM SPECIFIC REFUND DUE TO SURS. |
| 8085 | NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR. |
| 8086 | SAVE FOR FUTURE USE. |
| 8087 | SAVE FOR FUTURE USE. |
| 8088 | SAVE FOR FUTURE USE. |
| 8101 | SAVE FOR FUTURE USE. |
| 8102 | SAVE FOR FUTURE USE. |
| 8103 | SAVE FOR FUTURE USE. |
| 8104 | SAVE FOR FUTURE USE. |

| EOB Code | Description |
|---|---|
| 8105 | SAVE FOR FUTURE USE. |
| 8106 | SAVE FOR FUTURE USE. |
| 8107 | SAVE FOR FUTURE USE. |
| 8135 | EDS INITIATED OFFSET DUE TO PROCESSING ERROR |
| 8136 | INITIATED ADJUSTMENT DUE TO REVERSAL OF PREVIOUS PROCESSING OF RECOUP/CASH RECEIPT |
| 8141 | SAVE FOR FUTURE USE. |
| 8142 | SAVE FOR FUTURE USE. |
| 8143 | SAVE FOR FUTURE USE. |
| 8144 | SAVE FOR FUTURE USE. |
| 8145 | SAVE FOR FUTURE USE. |
| 8146 | SAVE FOR FUTURE USE. |
| 8147 | SAVE FOR FUTURE USE. |
| 8148 | SUPPLEMENTAL CLAIM VOID DUE TO ENCOUNTER VOID RECEIVED. |
| 8149 | ADJUSTMENT DUE TO SUPPLEMENTAL CLAIM PROCESSING. |
| 8166 | EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR. |
| 8167 | INITIATED ADJUSTMENT DUE TO REVERSAL PROCESSING OF RECOUP/CASH REFUND. |
| 8179 | YOUR VOID TRANSACTION HAS BEEN PROCESSED |
| 8180 | MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE. |
| 8181 | MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE |
| 8182 | MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE. |
| 8183 | MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE. |
| 8184 | MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE |
| 8185 | MASS ADJUSTMENT - RETROACTIVE RATE CHANGE. |
| 8186 | MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE). |
| 8187 | OTHER REQUEST FOR MASS ADJUSTMENT |
| 8188 | VOID TRANSACTIONS - MASS ADJUSTMENT |
| 8189 | MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED |
| 8190 | MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED |
| 8191 | MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST |
| 8192 | CLAIM ADJUSTED PER LEWIN MODEL DRG RATES. |
| 8199 | SAVE FOR FUTURE USE. |
| 8200 | TPL PRIVATE HEALTH INSURANCE - CARRIER |
| 8201 | TPL PRIVATE HEALTH INSURANCE - PROVIDER |
| 8202 | TPL PRIVATE HEALTH INSURANCE - MEMBER |
| 8203 | AUTO LIABILITY - CARRIER |
| 8204 | AUTO LIABILITY - PROVIDER |
| 8205 | AUTO LIABILITY - MEMBER |
| 8206 | NON-AUTO LIABILITY - CARRIE |
| 8207 | NON-AUTO LIABILITY - PROVIDER |
| 8208 | NON-AUTO LIABILITY - MEMBER |
| 8209 | WORKER'S COMP - CARRIER |
| 8210 | WORKER'S COMP - PROVIDER |
| 8211 | WORKER'S COMP - MEMBER |
| 8212 | PROBATE'S ESTATE |
| 8213 | INCOME PENSION TRUST RECOVERIES |
| 8214 | VICTIM'S RESTITUTION |
| 8215 | ABSENT PARENTS |
| 8216 | TPL ERROR |
| 8217 | DUE TO MISCELLANEOUS OR UNSPECIFIED REASON |
| 8220 | SAVE FOR FUTURE USE * TEMPORARILY USE FOR VOIDS * |
| 8221 | SAVE FOR FUTURE USE. |
| 8222 | SAVE FOR FUTURE USE |
| 8223 | SAVE FOR FUTURE USE. |
| 8224 | SAVE FOR FUTURE USE. |
| 8225 | CAPITATION - DEATH OF MEMBER |
| 8226 | CAPITATION - MEMBER INCARCERATED |
| 8227 | CAPITATION - EPSDT CLAIM |
| 8228 | CAPITATION - MEMBER ENROLLED IN ERROR |
| 8229 | CAPITATION - FAMILY PLANNING |
| 8230 | ICN VOIDED DUE TO WARRANT RETURN. |
| 8231 | CAPITATION - DEMOGRAPHIC CHANGE |
| 8232 | CAPITATION - OTHER |
| 8233 | SAVE FOR FUTURE USE. |
| 8234 | SAVE FOR FUTURE USE. |
| 8240 | ADJUSTMENT GENERATED DUE TO SURS REVIEW |
| 8241 | ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY |
| 8242 | ADJUSTMENT GENERATED DUE TO RATE CHANGE |
| 8244 | PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE |
| 8245 | POINT OF SALE |
| 8246 | POINT OF SALE REVERSAL |
| 8299 | ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE, AND PSYCHE RED |
| 8300 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE. |
| 8301 | A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXCLUDED FROM THE CHECKWRITE. |
| 8302 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE. |
| 8303 | A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENTHAS BEEN EXCLUDED FROM THE CHECKWRITE. |
| 8304 | PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE. |
| 8305 | PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE. |

| EOB Code | Description |
|---|---|
| 8306 | CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMOUNT OF REFUND BEING RETURNED TO PROVIDER. |
| 8307 | PAYOUT EXCLUDED FROM CHECKWRITE. |
| 8308 | PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT |
| 8309 | PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT |
| 8310 | PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT |
| 8311 | PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM |
| 8312 | PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT |
| 8313 | PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT |
| 8314 | PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR |
| 8315 | PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR |
| 8316 | PAYOUT DUE TO MANAGED CARE - OTHER |
| 8317 | PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW -CCU |
| 8318 | PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR |
| 8319 | PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR |
| 8320 | PAYOUT DUE TO PATIENT LIABILITY ERROR |
| 8321 | PAYOUT DUE TO PATIENT SPENDDOWN ERROR |
| 8322 | PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES |
| 8323 | PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION |
| 8325 | PAYOUT DUE TO GAS SURCHARGE. |
| 8326 | PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED. |
| 8327 | PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT. |
| 8328 | PAYOUT DUE TO DHS/DDSD AUDIT |
| 8329 | PAYOUT PROCESSED FROM STATE ONLY FUNDS |
| 8330 | PAYOUT DUE TO ELIGIBILITY NOT ON FILE. |
| 8331 | PAYOUT DUE TO CLAIM TOO OLD TO PROCESS |
| 8332 | PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON. |
| 8336 | RETROACTIVE INTEREST PAYMENT |
| 8352 | CAPITATION WARRANT VOID |
| 8399 | THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED. |
| 8400 | ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED . THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. |
| 8401 | DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS. |
| 8402 | DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8403 | DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8404 | DUE TO A LIABILITY & CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8405 | DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8406 | DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8407 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER |
| 8408 | DECREASE TO ORIGINAL LIEN AMOUNT. |
| 8409 | INCREASE TO ORIGINAL LIEN AMOUNT |
| 8410 | SAVE FOR FUTURE USE |
| 8411 | SAVE FOR FUTURE USE |
| 8412 | SAVE FOR FUTURE USE |
| 8413 | SAVE FOR FUTURE USE |
| 8414 | SAVE FOR FUTURE USE |
| 8415 | SAVE FOR FUTURE USE . |
| 8419 | SAVE FOR FUTURE USE |
| 8420 | AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8421 | AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8422 | AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8423 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT. |
| 8424 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE. |
| 8425 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE. |
| 8426 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUSTMENT. |
| 8427 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE.. |
| 8428 | AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8429 | AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8430 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR. |
| 8431 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS. |
| 8432 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD. |
| 8433 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW. |
| 8434 | AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8435 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR. |
| 8436 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR. |
| 8437 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW. |
| 8438 | AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS. |
| 8439 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY. |
| 8440 | SAVE FOR FUTURE USE. |
| 8441 | CLAIM GENERATED DUE TO ICN ON AR ROLLUP AND PARTIAL RECOUPMENT/REFUND APPLIED TO OFFSET. |
| 8442 | SAVE FOR FUTURE USE. |
| 8443 | SAVE FOR FUTURE USE. |
| 8444 | SAVE FOR FUTURE USE. |
| 8445 | SAVE FOR FUTURE USE. |
| 8446 | SAVE FOR FUTURE USE. |
| 8447 | SAVE FOR FUTURE USE. |
| 8448 | SAVE FOR FUTURE USE. |
| 8449 | SAVE FOR FUTURE USE. |
| 8450 | THIS ACCOUNT RECEIVABLE HAS BEEN CREATED DUE TO CAPITATION PROCESSING. |
| 8451 | DUE TO AN ADJUSTMENT SUBMITTED BY PROVIDER FOR A CLAIM TOO OLD TO PROCESS, AN ACCOUNT RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR P |
| 8452 | AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR. |

| EOB Code | Description |
|---|---|
| 8453 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND INCREASED THIS ACCOUNTS RECEIVABLE. |
| 8454 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND DECREASED THIS ACCOUNTS RECEIVABLE. |
| 8455 | THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORRECTED THE ACTION AND DECREASED THIS ACCOUNTS RECEIVABLE. |
| 8456 | CLAIM DUE TO CASH RECEIPT APPLIED TO AND DECREASED AN ACCTS RECEIVABLE. |
| 8457 | AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE |
| 8458 | A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE. |
| 8459 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW. |
| 8460 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW |
| 8461 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW. |
| 8462 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW. |
| 8463 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW. |
| 8464 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW. |
| 8465 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED. |
| 8466 | THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION |
| 8467 | THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION. |
| 8468 | THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF. |
| 8469 | THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET |
| 8470 | CLAIM DUE TO ACCOUNT RECEIVABLE AND INCREASED DUE TO PRV UNDERPAYMENT. |
| 8500 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER. |
| 8501 | PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED. |
| 8502 | PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY. |
| 8510 | CYCLE ACTIVITY |
| 8511 | DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. |
| 8512 | DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED. |
| 8513 | INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER. |
| 8514 | RELEASE OF LIEN RECEIVED BY LIEN HOLDER. |
| 8515 | YOUR VOID TRANSACTION HAS BEEN PROCESSED. |
| 8600 | ZERO CREDIT BALANCE |
| 8601 | PROV REFUND-HEALTH INSUR PAID |
| 8602 | PROV REFUND-RECIPIENT/REL PAID |
| 8603 | PROV REFUND-CASUALTY INSU PAID |
| 8604 | PROV REFUND-PAID WRONG VENDER |
| 8605 | PROV REFUND-APPLY TO ACCT RECV |
| 8606 | PROV REFUND-PROCESSING ERROR |
| 8607 | PROV REFUND-BILLING ERROR |
| 8608 | PROV REFUND-FRAUD |
| 8609 | PROV REFUND-ABUSE |
| 8610 | PROV REFUND-DUPLICATE PAYMENT |
| 8611 | PROV REFUND-COST SETTLEMENT |
| 8612 | PROV REFUND-OTHER/UNKNOWN |
| 8613 | ACCT RECEIVABLE - FRAUD |
| 8614 | ACCT RECEIVABLE - ABUSE |
| 8615 | ACCT RECEIVABLE - TPL |
| 8616 | ACCT RECV - COST SETTLEMENT |
| 8617 | ACCT RECEIVABLE-KYMMIS REQUEST |
| 8618 | RECOUPMENT - WARRANT REFUND |
| 8619 | ACT RECEIVABLE-SURS OTHER |
| 8620 | ACCT RECEIVABLE - DUP PAYT |
| 8621 | RECOUPMENT - FRAUD |
| 8622 | CIVIL MONEY PENALTY |
| 8623 | RECOUPMENT-HEALTH INSUR TPL |
| 8624 | RECOUPMENT-CASUALTY INSUR TPL |
| 8625 | RECOUPMENT-RECIPIENT PAID TPL |
| 8626 | RECOUPMENT - PROCESSING ERROR |
| 8627 | RECOUPMENT - BILLING ERROR |
| 8628 | RECOUPMENT - COST SETTLEMENT |
| 8629 | RECOUPMENT - DUPLICATE PAYMENT |
| 8630 | RECOUPMENT - PAID WRONG VENDOR |
| 8631 | RECOUPMENT - SURS |
| 8632 | PAYOUT-ADVANCE TO BE RECOUPED |
| 8633 | PAYOUT - ERROR ON REFUND |
| 8634 | PAYOUT - RTP |
| 8635 | PAYOUT - COST SETTLEMENT |
| 8636 | PAYOUT - OTHER |
| 8637 | PAYOUT - MEDICARE PAID TPL |
| 8638 | RECOUPMENT - MEDICARE PAID TPL |
| 8639 | RECOUPMENT - DEDCO |
| 8640 | PROVIDER REFUND-OTHER TPL RSN |
| 8641 | ACCT RECV - PATIENT ASSESSMENT |
| 8642 | ACCT RECV - ORTHODONTIC FEE |
| 8643 | ACCT RECEIVABLE - KENPAC |
| 8644 | PARTICIP REQUIREMENTS FAILURE |
| 8645 | ACCT RECEIVABLE - OTHER |
| 8646 | AR CDR HOSP AUDIT |
| 8647 | ACT REC-DEMAND PAYMT UPDT 1099 |
| 8648 | ACT REC-DEMAND PAYMT NO 1099 |
| 8649 | PCG - PART A RECOVERIES |
| 8650 | RECOUPMENT - COLD CHECK |
| 8651 | PROG INTRE POST PAY REV CONT A |
| 8652 | PROG INTRE POST PAY REV CONT B |

| EOB Code | Description |
|---|---|
| 8653 | CLAIM CREDIT BALANCE |
| 8654 | RECOUPMENT-OTHER ST BRANCH |
| 8655 | RECOUPMENT - OTHER |
| 8656 | RECOUPMENT - TPL CONTRACTOR |
| 8657 | ACCT RECV - ADVANCE PAYMENT |
| 8658 | RECOUPMENT - ADVANCE PAYMENT |
| 8659 | NON CLAIM RELATED OVERAGE |
| 8660 | PROVIDER INITIATED ADJUSTMENT |
| 8661 | PROVIDER INITIATED CLM CREDIT |
| 8662 | CLM CR-PAID MEDICAID VS XOVER |
| 8663 | CLM CR-PAID XOVER VS MEDICAID |
| 8664 | CLM CR-PAID INPATIENT VS OUTP |
| 8665 | CLM CR-PAID OUTPATIENT VS INP |
| 8666 | CLM CREDIT-PROV NUMBER CHANGED |
| 8667 | TPL CLM NOT FOUND ON HISTORY |
| 8668 | FIN CLM NOT FOUND ON HISTORY |
| 8669 | FINANCIAL WITHHOLD PAYMENT |
| 8670 | KENPAC INCENTIVE PAYMENT |
| 8671 | ENC DATA UNACCEPTABLE |
| 8672 | AR OVERAGE LT 99 |
| 8673 | NO MEDICAID/PARTNERSHIP ENROLL |
| 8674 | PROV DATA  UNACCEPTABLE |
| 8675 | PCP DATA UNACCEPTABLE |
| 8676 | WITHOLD OTHER |
| 8677 | RECIP INTENTIONAL PGM VIOLATE |
| 8678 | CAP ADJUSTMENT OTHER |
| 8679 | RECIPIENT NOT ELIGIBLE FOR DOS |
| 8680 | ADHOC ADJUSTMENT REQUEST |
| 8681 | ADJ DUE TO SYSTEM CORRECTIONS |
| 8682 | CONVERTED ADJUSTMENT |
| 8683 | MASS ADJ WARR REFUND |
| 8684 | DMS MASS ADJ REQUEST |
| 8685 | MASS ADJ SURS REQUEST |
| 8686 | THIRD PARTY PAID - TPL |
| 8687 | CLAIM ADJUSTMENT - TPL |
| 8688 | BEGINNING DUMMY RECOUPMENT BAL |
| 8689 | ENDING DUMMY RECOUPMENT BAL |
| 8690 | RETRO RATE MASS ADJ |
| 8691 | BEGINNING CREDIT BALANCE |
| 8692 | ENDING CREDIT BALANCE |
| 8693 | BEGINNING DUMMY CREDIT BALANCE |
| 8694 | ENDING DUMMY CREDIT BALANCE |
| 8695 | BEGINNING RECOUPMENT BALANCE |
| 8696 | ENDING RECOUPMENT BALANCE |
| 8697 | BEGIN DUMMY REC BAL |
| 8698 | END DUMMY RECOUP BALANCE |
| 8699 | UNIT DOSE RETURN DRUG ADJ |
| 8700 | PCG 2 PART A RECOVERIES |
| 8701 | PCG 2 PART B RECOVERIES |
| 8702 | PCG 2 AR CDR HOSP |
| 8703 | CONVERTED CLAIM CREDIT BALANCE |
| 8704 | DRG RETRO REVIEW |
| 8705 | DECEASED RECIPIENT RECOUPMENTS |
| 8706 | IMPACT PLUS |
| 8707 | INTEREST RECEIVED |
| 8708 | PROG INTRE POST PAY REV CONT C |
| 8709 | ON DEMAND RECOUPMENT REFUND |
| 8710 | RECOUP PAYOUT |
| 8711 | RECOUPMENT REFUND |
| 8712 | STATE SHARE |
| 8713 | KYMMIS MEDICARE PART A RECOUP |
| 8714 | REG. PSYCH. CROSSOVER REFUND |
| 8998 | CLAIM BEING REVIEWED |
| 8999 | ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95.  THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE, AND PSYCHE REDUCTION AMOUNTS. |
| 9000 | THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE.  CLAIM PAID AT THE KY MEDICAIDALLOWED AMOUNT. |
| 9001 | REIMBURSEMENT REDUCED BY THE MEMBER'S CO-PAYMENT AMOUNT. |
| 9002 | ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE. PLEASE RESUBMIT WITH AN INVOICE. |
| 9003 | NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT. |
| 9004 | PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE  ALLOWED AMOUNT. |
| 9005 | COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURES ON THE SAME DATE OF SERVICE. |
| 9006 | THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE. |
| 9007 | A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT WITH A PROCEDURE CODE. |
| 9008 | LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION.  PLEASE RESUBMIT WITH APPROPRIATEAND/OR ADDITIONAL INFORMATION. |
| 9009 | SERVICE DENIED.  REIMBURSEMENT FOR INPATIENT HOSPITAL CARE LIMITED TO ONCE PER DAY. |
| 9010 | SERVICE IS NON-COVERED UNDER THE OKLAHOMA HEALTH COVERAGE PROGRAM |
| 9011 | SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM. |
| 9012 | WRONG CLAIM FORM SUBMITTED.  PLEASE RESUBMIT ON A UB92 CLAIM FORM. |
| 9013 | CLAIM UNDER REVIEW - FOR INTERNAL USE ONLY |

| EOB Code | Description |
|---|---|
| 9015 | MCO CANNOT ADJUST OR VOID A FEE-FOR-SERVICE CLAIMS AND VICE VERSA. |
| 9016 | THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DATES OF SERVICE BILLED ON THE CLAIM DETAILS. THE OVERHEAD FEE WAS APPLIED TO ALL DET |
| 9017 | SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PROCEDURE HAS BEEN PAID. |
| 9018 | 837 ADJUSTMENT ERROR -- MEMBER MEDICAID ID NOT PRESENT |
| 9019 | 837 ADJUSTMENT ERROR -- CROSSOVER PROVIDER ID NOT PRESENT |
| 9020 | 837 ADJUSTMENT ERROR -- PROVIDER ID NOT PRESENT |
| 9021 | 837 ADJUSTMENT ERROR -- UNABLE TO FIND ORIGINAL ICN |
| 9022 | YOU CANNOT ADJUST OR VOID A THRESHOLDED ENCOUNTER. |
| 9023 | 837 ADJUSTMENT ERROR -- RECIPIENT NOT FOUND |
| 9024 | 837 ADJUSTMENT ERROR -- PROVIDER NOT FOUND |
| 9025 | 837 ADJUSTMENT ERROR -- MATCHING CLAIM NOT FOUND |
| 9026 | 837 ADJUSTMENT ERROR -- CLAIM HAS ALREADY BEEN ADJUSTED |
| 9027 | 837 ADJUSTMENT ERROR -- CLAIM IS SCHEDULED TO BE ADJUSTED BY ANOTHER PROCESS |
| 9028 | 837 ADJ ERROR- PROV/TAXNMY/ZIP NOT MATCHING ORGIN |
| 9029 | 837 ADJ-CURRENT CLAIM TYPE NOT MATCHING ORIGN |
| 9030 | CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY PAID FOR PROCEDURES INCLUDED IN THE VISIT CODE EQUAL THE REIMBURSEMEN |
| 9031 | GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIMBURSED FOR THE RELATED COMPONENT IMMUNIZATION PROCEDURE(S) EQUALS THE REIMBURSE |
| 9032 | CLAIM DENIED. EDI ADJUSTMENT NOT ALLOWED FOR ELECTRONIC CLAIM WITH ATTACHMENTS. |
| 9036 | ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVICE EXCEEDS OKLAHOMA HEALTH COVERAGE PROGRAM ALLOWABLE FOR THE PROCEDURE BILLED. |
| 9040 | REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTR ATION FEE ONLY |
| 9075 | CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY COMPLETED.A STERILIZATION CHECKLIST AND YOUR CLAIM ARE BEING SENT TO YOU WITH THE ERRORS/OM |
| 9080 | NON COVERED CHARGES |
| 9090 | XOVER W/O MEDICARE SEGMENT FOR REVIEW |
| 9091 | NO MEDICARE CROSSOVER COPAY DUE |
| 9107 | FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN THE AMOUNT PAID FOR COMPONENTS OF THESPINAL SERIES X-RAYS WITHIN THE SAME CALENDAR YEAR EQUAL THE REIMBURSMENT AMOU |
| 9111 | INTERNAL PROCESSING ERROR - CONTACT SE MANAGER |
| 9122 | NO PRICING METHOD ASSIGNED OR UNKNOWN |
| 9175 | CLAIM DENIED. MEMBER'S SIGNATURE AND DATE OF SIGNATURE IN THE MEMBER'S SECTIONOF THE CONSENT FORM ARE IN ERROR AND ARE NON CORRECTABLE FIELDS. |
| 9256 | TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF $850.00 PER MONTH, BUT IS NOT PAYABLE WHEN RELATED COMPONENTS HAVE BEEN REIMBURSED FOR THE MAXIMUM AMOUNT. |
| 9257 | MAXIMUM REIMBURSEMENT FOR OXIMETRY IS $280.00 PER 30 DAYS. MAXIMUM REIMBURSEMENT HAS BEEN PAID. |
| 9260 | PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIES HAVE BEEN PAID WITHIN THE SAME THIRTY DAY (30) TIME PERIOD. REIMBURSEMENT REF |
| 9300 | MASS ADJUSTMENT SUSPENDED FOR REVIEW |
| 9302 | INVALID BENEFIT PLAN ON CLAIM |
| 9303 | UNABLE TO ASSIGN PROVIDER CONTRACT |
| 9304 | DUE TO CONDITIONS NOT PRESENT ON ADMISSION, SOME DIAGNOSIS CODES WERE NOT CONSIDERED IN THE DRG ASSIGNMENT PROCESS. THIS MAY HAVE AFFECTED YOUR PAYMENT. |
| 9400 | THE NUMBER OF SERVICES EXCEED MEDICAL POLICY GUIDELINES. PRIOR AUTHORIZATION REQUIRED FOR ADDITIONAL SERVICES. |
| 9500 | SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED. |
| 9501 | SUPPLEMENTAL CLAIM CREATED DUE TO MCO ENCOUNTER RECEIVED. NO SUPPLEMENTAL PAYMENT DUE. |
| 9502 | PAID AMOUNT OF A FEE-FOR-SERVICE MY REWARDS CLAIM HAS BEEN DEDUCTED FROM YOUR SUPPLEMENTAL CLAIM PAYMENT. |
| 9600 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS |
| 9601 | REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS |
| 9603 | THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBER'S SPENDOWN MET DATE FORTHE MONTH. AN 8A FORM IS REQUIRED. POS PROVIDERS MUST SUBMIT THIS CLAIM ON P APE |
| 9604 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YEARS FOR MEMBERS 19 YEARS OF AGE OR OLDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHE |
| 9605 | HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD BE DISCHARGED AND READMITTED FOLLOWING THE HOSPITAL STAY. |
| 9634 | COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURE ON THE SAME DATE OF SERVICE. |
| 9651 | SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PERCENT OF THE OKLAHOMA HEALTH COVERAGE PROGRAM'S ALLOWED. |
| 9660 | THIS SERVICE IS NOT PAYABLE, MEMBER IS QMB ALSO AND SPENDDOWN HAS NOT BEEN MET FOR THE MONTH. ONLY REIMBURSEMENT FOR COINSURANCE AND DEDUCTIBLE ON CLAIMS CRO |
| 9661 | POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE |
| 9662 | CLAIM DENIED. ATTACHMENT NOT RECEIVED. |
| 9663 | ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM. |
| 9664 | THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED. |
| 9665 | TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS. |
| 9666 | THE ATTACHMENT TYPE IS NOT VALID. |
| 9700 | THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE |
| 9701 | THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY |
| 9702 | DOLLARS ADJUSTED TO PARAMETER LIMIT |
| 9703 | QTY ADJUSTED TO PARAMETER LIMIT |
| 9704 | COVERED DAYS REDUCED TO ALLOWABLE |
| 9705 | VISITS REDUCED TO AUTHORIZED |
| 9706 | PA CHARGE REDUCED TO AUTHORIZED |
| 9707 | PA UNITS REDUCED TO AUTHORIZED |
| 9708 | THER DAYS REDUCED TO AUTHORIZED |
| 9709 | MAX 14 CONSECUTIVE THER DAYS ALLOWED |
| 9710 | HOSP LEAVE DAYS REDUCED TO AUTHORIZED |
| 9800 | CUTBACK DUE TO HMO PAYMENT |

| EOB Code | Description |
|---|---|
| 9878 | THE SUM OF THE OTHER PAYER DETAIL PAID AMOUNT PLUS THE OTHER PAYER CLAIM DETAILADJUSTMENT AMOUNTS MUST EQUAL THE CLAIM DETAIL BILLED AMOUNT. |
| 9900 | REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENTS ARE DUE TO EXTENUATING CIRCUMSTANCE |
| 9901 | REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENT IS DUE TO EXTENUATING CIRCUMSTANCES |
| 9902 | PROCEDURE CODE GROUP NOT FOUND |
| 9903 | REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS FOR MEMBERS 19 YEARS OF AGE OR OLDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHENMEM |
| 9904 | SERVICE DENIED. REIMBURSEMENT LIMITED TO ONE SET OF LENSES EVERY TWO YEARS FORMEMBERS 19 YEARS OR OLDER UNLESS REPAIRS OR REPLACEMENT IS DUE TO EXTENUATI NG |
| 9905 | SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STATING REASON FOR MEDICAL NECESSITY. |
| 9906 | PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED |
| 9907 | TPL AMOUNT APPLIED |
| 9908 | PRICING ADJUSTMENT - PHARMACY PRICING APPLIED |
| 9909 | PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED |
| 9910 | PHARMACY DISPENSING FEE APPLIED |
| 9911 | PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED |
| 9912 | PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED |
| 9913 | PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED |
| 9914 | PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED |
| 9915 | PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED |
| 9916 | PRICING ADJUSTMENT - UCC RATE PRICING APPLIED |
| 9917 | PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED |
| 9918 | PRICING ADJUSTMENT - MAX FEE PRICING APPLIED |
| 9919 | PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED |
| 9920 | PRICING ADJUSTMENT - RBRVS PRICING APPLIED |
| 9921 | PRICING ADJUSTMENT - PA PRICING APPLIED |
| 9922 | SPENDDOWN DEDUCTIBLE/PATIENT LIABILITY APPLIED |
| 9923 | SPENDDOWN PATIENT LIABILITY APPLIED |
| 9924 | CLAIM HAS FICA AMOUNT |
| 9925 | CLAIM HAS RECOUPMENT AMOUNT |
| 9926 | CLAIM HAS CUTBACK AMOUNT |
| 9927 | SYSTEM FUND CODE REASSIGNMENT |
| 9928 | PRICING ADJUSTMENT - COVID VACCINATION ADMINISTRATION OR CHW PRICING APPLIED. |
| 9930 | REVENUE CODE ZERO PAID WHEN BILLED WITH THIS PROCEDURE CODE. |
| 9931 | PRICING ADJUSTMENT - 100% MEDICARE COINS. & DEDUCT APPLIED |
| 9932 | PRICING ADJUSTMENT - DRG PRICING APPLIED |
| 9933 | PRICING ADJUSTMENT - APC PRICING APPLIED |
| 9934 | PRICING ADJUSTMENT - UCC FLAT FEE 3 PRICING APPLIED |
| 9935 | PRICING ADJUSTMENT - MAX FLAT FEE PRICING APPLIED |
| 9936 | PRICING ADJUSTMENT - MAX FLAT FEE 2 PRICING APPLIED |
| 9937 | PRICING ADJUSTMENT - UCC FLAT FEE PRICING APPLIED |
| 9938 | PRICING ADJUSTMENT - UCC FLAT FEE 2 PRICING APPLIED |
| 9939 | PRICING ADJUSTMENT - SCHOOL BASED GROUP PRICING APPLIED |
| 9940 | PRICING ADJUSTMENT - PROVIDER PERCENT BILLED APPLIED |
| 9941 | PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED |
| 9942 | PRICING ADJUSTMENT- MEMBER COUNTY PRICING APPLIED. |
| 9943 | PRICING ADJUSTMENT-HOSPICE CROSSWALK PRICING APPLIED. |
| 9944 | PRICING ADJUSTMENT - LESSER PA/MAX FEE PRICING APPLIED |
| 9945 | PRICING ADJUSTMENT - PROVIDER UNIT RATE PRICING APPLIED |
| 9946 | PRICING ADJUSTMENT- PROVIDER SPECIFIC PER DIEM RATES APPLIED |
| 9947 | PRICING ADJUSTMENT - BUNDLED RATE PRICING APPLIED |
| 9948 | OUTPATIENT ASC PRICING APPLIED |
| 9949 | INPATIENT AUTOMATED TRANSPLANT PRICING APPLIED |
| 9950 | PRICING ADJUSTMENT- PPDADD PRICING APPLIED |
| 9951 | PRICING ADJUSTMENT- PROVIDER MAX PER DIEM PRICING APPLIED |
| 9952 | PRICING ADJUSTMENT- REVENUE PCT PRICING APPLIED |
| 9953 | PRICING ADJUSTMENT- ZERO PAID PRICING APPLIED |
| 9954 | KY DEFAULT PERCENTAGE PRICING APPLIED |
| 9955 | PRICING ADJUSTMENT - LESSER ANESTHESIA PRICING APPLIED |
| 9956 | PRICING ADJUSTMENT - NDC PRICING APPLIED |
| 9957 | PRICING ADJUSTMENT - REVENUE FEE PERCENTAGE PRICING APPLIED. |
| 9958 | PRICING ADJUSTMENT - PROVIDER PERCENTAGE OF PER DIEM PRICING APPLIED. |
| 9965 | TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES A QUADRANT. |
| 9970 | PRICING ADJUSTMENT - LT1918 PRICING APPLIED |
| 9971 | PRICING ADJUSTMENT - LTCPTA PRICING APPLIED |
| 9972 | PRICING ADJUSTMENT - LTNQMB PRICING APPLIED |
| 9973 | PRICING ADJUSTMENT - LTPD18 PRICING APPLIED |
| 9975 | PRICING ADJUSTMENT - LTCDME PRICING APPLIED |
| 9977 | CLAIM DENIED. THE SUM OF ALL LINE LEVEL PAYMENT AMOUNTS LESS ANY CLAIM LEVEL ADJUSTMENT AMOUNTS DOES NOT BALANCE TO THE CLAIM LEVEL PAYMENT AMOUNT. |
| 9980 | PROVIDER TYPE SPECIALTY GROUP NOT FOUND |
| 9981 | DIAGNOSIS CODE GROUP NOT FOUND |
| 9983 | ICD PROCEDURE CODE GROUP NOT FOUND |
| 9984 | MODIFIER CODE GROUP NOT FOUND |
| 9985 | NDC DRUG TYPE GROUP NOT FOUND |
| 9986 | REVENUE CODE GROUP NOT FOUND |
| 9987 | DRG CODE GROUP NOT FOUND |
| 9988 | TYPE OF BILL GROUP NOT FOUND |
| 9990 | BENEFIT PLAN TYPE GROUP NOT FOUND |

| EOB Code | Description |
|---|---|
| 9991 | REFUND AMOUNT LESS THAN ADJUSTED AMOUNT |
| 9992 | REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT |
| 9995 | ADJUSTMENT DETAIL MANUALLY DENIED |
| 9996 | PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION. |
| 9997 | PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES COLLECTED FOR THE MEMBER IN THE SAME MONTH. |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT KENTUCKY HEALTH COVERAGE PROGRAM POLICIES. |
| 9999 | PROCESSED PER MEDICAID POLICY |