



J. Provider Remittance Advice (RA) Codes

Section J.1 lists the Explanation of Benefit (EOB), Adjustment Reason Codes and Remark Codes that may appear on a Provider Remittance Advice (RA) for paid, denied, or adjusted claims.

J.1 Explanation of Benefit (EOB) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 201 | INVALID PAY-TO PROVIDER NUMBER | 125 | N280 |
| 202 | BILLING PROVIDER ID IN INVALID FORMAT | 125 | N257 |
| 203 | RECIPIENT I.D. NUMBER MISSING | 31 | N382 |
| 206 | PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT | 16 | N31 |
| 210 | BRAND MEDICALLY NECESSARY INDICATOR INVALID | 125 | |
| 211 | INVALID REFILL INDICATOR VALUE | 16 | |
| 212 | MISSING PRESCRIPTION NUMBER | 16 | N388 |
| 215 | DATE DISPENSED IS MISSING | 16 | N304 |
| 216 | DATE DISPENSED IS INVALID | 16 | N304 |
| 217 | MISSING DRUG CODE | 16 | M119 |
| 218 | INVALID DRUG CODE | 16 | M119 |
| 219 | QUANTITY DISPENSED IS MISSING | 16 | N378 |
| 220 | QUANTITY DISPENSED IS INVALID | 16 | N378 |
| 223 | MISSING DIAGNOSIS INDICATOR | 16 | M76 |
| 224 | DIAGNOSIS TREATMENT INDICATOR INVALID | 16 | M76 |
| 225 | REFERRING PROVIDER - INVALID FORMAT | 16 | N286 |
| 226 | ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER | 16 | N286 |
| 228 | CLAIMANT SIGNATURE MISSING | 16 | MA75 |
| 229 | SOURCE OF ADMISSION MISSING | 16 | MA42 |
| 230 | MISSING ATTENDING SURGEON PRESCRIBER NUMBER | 16 | N262 |
| 231 | CLAIM WAS FILED WITHOUT SERVICING PROVIDER | 16 | N290 |
| 233 | UNITS OF SERVICE MISSING | 16 | M53 |
| 234 | PROCEDURE CODE MISSING | 16 | M51 |
| 235 | PROCEDURE CODE NOT IN VALID FORMAT | 16 | M51 |
| 238 | RECIPIENT NAME IS MISSING | 16 | MA36 |
| 239 | DETAIL TO DATE OF SERVICE IS MISSING | 16 | M59 |
| 240 | THE DETAIL "TO" DATE IS INVALID | 16 | M59 |
| 243 | MISSING MEDICARE PAID DATE | 226 | N307 |
| 245 | MISSING OCCURRENCE CODE | 129 | |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 247 | MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED | 16 | |
| 248 | PLACE OF SERVICE IS MISSING OR BLANK | 16 | M77 |
| 249 | PLACE OF SERVICE IS INVALID | 16 | M77 |
| 250 | CLAIM HAS NO DETAILS | 16 | M77 |
| 258 | MISSING DIAGNOSIS CODE | 16 | M76 |
| 259 | DATE BILLED IS INVALID | 16 | MA31 |
| 260 | UNITS OF SERVICE NOT IN VALID FORMAT | 16 | M53 |
| 261 | MISSING TOOTH NUMBER | 16 | N37 |
| 262 | INVALID TOOTH NUMBER | 16 | N37 |
| 263 | INVALID TOOTH SURFACE | 16 | N75 |
| 264 | DETAIL FROM DATE OF SERVICE IS MISSING | 16 | M52 |
| 265 | DETAIL FROM DATE OF SERVICE IS INVALID | 16 | M52 |
| 266 | MISSING TOOTH SURFACE | 16 | N75 |
| 268 | BILLED AMOUNT INVALID | 16 | M79 |
| 269 | DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT | 16 | M79 |
| 270 | MISSING TOTAL CLAIM CHARGE | 16 | M54 |
| 271 | INVALID TOTAL CLAIM CHARGE | 16 | M54 |
| 273 | TYPE OF BILL MISSING | 16 | MA30 |
| 274 | TYPE OF BILL CODE INVALID | 16 | MA30 |
| 275 | ADMIT DATE MISSING | 16 | MA40 |
| 276 | ADMIT DATE INVALID | 16 | MA40 |
| 277 | INVALID ADMISSION HOUR | 16 | N46 |
| 278 | ADMIT TYPE MISSING | 16 | MA41 |
| 279 | INVALID TYPE OF ADMISSION | 16 | MA41 |
| 280 | PATIENT STATUS IS MISSING | 16 | MA43 |
| 281 | PATIENT STATUS IS INVALID | 16 | MA43 |
| 282 | MISSING COVERED DAYS | 16 | MA32 |
| 283 | COVERED DAYS INVALID | 16 | MA32 |
| 284 | PRIMARY CONDITION CODE INVALID | 16 | M44 |
| 285 | SECOND CONDITON CODE INVALID | 16 | M44 |
| 286 | THIRD CONDITION CODE INVALID | 16 | M44 |
| 287 | FOURTH CONDITION CODE INVALID | 16 | M44 |
| 288 | FIFTH CONDITION CODE INVALID | 16 | M44 |
| 289 | SIXTH CONDITION CODE INVALID | 16 | M44 |
| 290 | SEVENTH CONDITION CODE INVALID | 16 | M44 |
| 291 | PRIMARY OCCURRENCE CODE INVALID | 129 | M44 |
| 292 | SECOND OCCURRENCE CODE INVALID | 129 | M45 |
| 293 | THIRD OCCURRENCE CODE INVALID | 16 | M45 |
| 294 | FOURTH OCCURRENCE CODE INVALID | 129 | M45 |
| 295 | DATE FOR PRIMARY OCCURRENCE CODE MISSING | 16 | N299 |
| 296 | DATE FOR PRIMARY OCCURRENCE CODE INVALID | 16 | N299 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 297 | DATE FOR SECOND OCCURRENCE CODE MISSING | 16 | N299 |
| 298 | DATE FOR SECOND OCCURRENCE CODE INVALID | 16 | N299 |
| 299 | DATE FOR THIRD OCCURRENCE CODE MISSING | 16 | N299 |
| 300 | DATE FOR THIRD OCCURRENCE CODE INVALID | 16 | N299 |
| 301 | DATE FOR FOURTH OCCURRENCE CODE MISSING | 16 | N299 |
| 302 | DATE FOR FOURTH OCCURRENCE CODE INVALID | 16 | N299 |
| 339 | REVENUE CODE IS MISSING | 16 | M50 |
| 340 | REVENUE CODE IS INVALID | 16 | M50 |
| 350 | THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT | 16 | M50 |
| 363 | PRINCIPAL ICD9 PROCEDURE CODE IS INVALID | 16 | |
| 364 | PRINCIPAL ICD9 PROCEDURE DATE MISSING | 16 | N303 |
| 365 | PRINCIPAL ICD9 PROCEDURE DATE INVALID | 16 | N303 |
| 366 | FIRST OTHER PROCEDURE CODE INVALID | 16 | |
| 367 | FIRST OTHER ICD9 PROCEDURE DATE MISSING | 16 | N302 |
| 368 | FIRST OTHER ICD9 PROCEDURE DATE INVALID | 16 | N302 |
| 369 | SECOND OTHER PROCEDURE CODE INVALID | 16 | M67 |
| 370 | SECOND OTHER ICD9 PROCEDURE DATE MISSING | 16 | N302 |
| 371 | SECOND OTHER ICD9 PROCEDURE DATE INVALID | 16 | N302 |
| 372 | THIRD OTHER PROCEDURE CODE INVALID | 16 | |
| 373 | THIRD OTHER ICD9 PROCEDURE DATE MISSING | 16 | N302 |
| 374 | THIRD OTHER ICD9 PROCEDURE DATE INVALID | 16 | N302 |
| 375 | FOURTH OTHER PROCEDURE CODE INVALID | 16 | |
| 376 | FOURTH OTHER ICD9 PROCEDURE DATE MISSING | 16 | N302 |
| 377 | FOURTH OTHER ICD9 PROCEDURE DATE INVALID | 16 | N302 |
| 378 | FIFTH OTHER PROCEDURE CODE INVALID | 16 | |
| 379 | FIFTH OTHER ICD9 PROCEDURE DATE MISSING | 16 | N302 |
| 380 | FIFTH OTHER ICD9 PROCEDURE DATE INVALID | 16 | N302 |
| 381 | ATTENDING PHYSICIAN PROVIDER NUMBER MISSING | 16 | N253 |
| 395 | HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING | 16 | M52 |
| 396 | HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID | 16 | M52 |
| 397 | HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING | 16 | M52 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 398 | STATEMENT COVERS PERIOD "THROUGH" DATE INVALID | 16 | M52 |
| 400 | DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO | 16 | M53 |
| 405 | FIFTH OCCURRENCE CODE INVALID | 129 | M53 |
| 406 | SIXTH OCCURRENCE CODE INVALID | 129 | M45 |
| 407 | SEVENTH OCCURRENCE CODE INVALID | 129 | M45 |
| 408 | EIGHTH OCCURRENCE CODE INVALID | 129 | M45 |
| 409 | FIRST OCCURRENCE SPAN CODE INVALID | 129 | M45 |
| 410 | SECOND OCCURRENCE SPAN CODE INVALID | 129 | M45 |
| 411 | DATE FOR FIFTH OCCURRENCE CODE MISSING | 16 | N299 |
| 412 | DATE FOR FIFTH OCCURRENCE CODE INVALID | 16 | N299 |
| 413 | DATE FOR SIXTH OCCURRENCE CODE MISSING | 16 | N299 |
| 414 | DATE FOR SIXTH OCCURRENCE CODE INVALID | 16 | N299 |
| 415 | DATE FOR SEVENTH OCCURRENCE CODE MISSING | 16 | N299 |
| 416 | DATE FOR SEVENTH OCCURRENCE CODE INVALID | 16 | N299 |
| 417 | DATE FOR EIGHTH OCCURRENCE CODE MISSING | 16 | N299 |
| 418 | DATE FOR EIGHTH OCCURRENCE CODE INVALID | 16 | N299 |
| 419 | FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING | 16 | M45 |
| 420 | FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID | 92 | M46 |
| 421 | TO DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING | 92 | M100 |
| 422 | TO DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID | 92 | M100 |
| 423 | FROM DAT OF SERV FOR 2ND OCCUR SPAN CODE MISSING | 92 | M100 |
| 424 | FROM DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID | 92 | M100 |
| 425 | TO DTE OF SERV FOR 2ND OCCUR SPAN CODE MISSING | 92 | M100 |
| 426 | TO DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID | 92 | M100 |
| 433 | MEDICARE DEDUCTIBLE AMOUNT INVALID | 1 | M100 |
| 434 | MEDICARE COINSURANCE AMOUNT INVALID | 2 | |
| 435 | MEDICARE BLOOD DEDUCTIBLE AMOUNT INVALID | 92 | |
| 436 | TOTAL MEDICARE ALLOWED AMOUNT INVALID | 125 | N219 |
| 450 | INVALID QUADRANT | 16 | N346 |
| 451 | NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE | 2 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 455 | DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED | 125 | N183 |
| 456 | INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER | 16 | M51 |
| 457 | INVALID PRINCIPAL/OTHER PROCEDURE TYPE | 16 | M51 |
| 460 | THE ATTACHMENT TYPE IS NOT VALID. | 16 | N228 |
| 461 | VALUE CODE IS INVALID | 16 | M49 |
| 462 | VALUE CODE AMOUNT IS MISSING | 16 | M49 |
| 463 | VALUE CODE AMOUNT IS INVALID | 16 | M49 |
| 464 | OCCURRENCE CODE 9-24 INVALID | 129 | |
| 465 | DATE FOR OCCURRENCE CODE 9-24 MISSING | 16 | N299 |
| 466 | DATE FOR OCCURRENCE CODE 9-24 INVALID | 16 | N299 |
| 467 | OCCURRENCE SPAN CODE 9-24 INVALID | 16 | M46 |
| 468 | FROM DATE OF SERVICE FOR SPAN CODE 3-24 MISSING | 16 | N300 |
| 469 | FROM DATE OF SERVICE FOR SPAN CODE 3-24 INVALID | 16 | N300 |
| 470 | TO DATE OF SERVICE FOR SPAN CODE 3-24 MISSING | 16 | N300 |
| 471 | CONDITION CODE 8-24 INVALID | 16 | M44 |
| 472 | TO DATE OF SERVICE FOR SPAN CODE 3-24 INVALID | 92 | M44 |
| 473 | ICD9 PROCEDURE 7-24 INVALID | 16 | M100 |
| 474 | ICD9 PROCEDURE 7-24 OR DATE MISSING | 16 | N301 |
| 475 | ICD9 PROCEDURE 7-24 DATE INVALID | 16 | N301 |
| 477 | DETAIL FIRST OTHER PHYSICIAN ID INVALID | 16 | N262 |
| 480 | THE ATTACHMENT TYPE IS NOT VALID. | 16 | N228 |
| 500 | DATE PRESCRIBED AFTER BILLING DATE | 125 | N57 |
| 502 | DATE DISPENSED EARLIER THAN DATE PRESCRIBED | 16 | N304 |
| 503 | DATE DISPENSED AFTER BILLING DATE | 110 | N304 |
| 506 | DATE DISPENSED AFTER ICN DATE | 45 | |
| 507 | FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV | 16 | MA31 |
| 508 | TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS | 16 | M54 |
| 511 | 2ND OCCURRENCE SPAN FROM DATE IS AFTER THE TO DATE | 16 | M46 |
| 512 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 | M46 |
| 513 | NAME ON CLAIM MUST MATCH NAME ON FILE | 140 | MA36 |
| 514 | DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV | 110 | M59 |
| 519 | ADMIT DATE GREATER THAN FIRST DATE OF SERVICE | 110 | MA40 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 526 | DETAIL DATES NOT WITHIN HEADER DATES | 16 | MA31 |
| 527 | DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE | 16 | M52 |
| 536 | BILLED DATE IS PRIOR TO DATES OF SERVICE | 16 | |
| 537 | HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE | 125 | MA31 |
| 545 | PHARMACY CLAIM FILED BEYOND 365-DAY FILING | 100 | |
| 554 | HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE | 16 | MA31 |
| 555 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 | M100 |
| 556 | SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT | 29 | |
| 565 | HEADER PAID AMOUNT IS GREATER THAN BILLED AMOUNT | 92 | |
| 568 | DISCHARGE DATE IS LESS THAN ADMIT DATE | 16 | |
| 569 | DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV | 16 | N305 |
| 570 | TOTAL DAYS LESS THAN COVERED DAYS | 16 | MA32 |
| 571 | SURGICAL PROCEDURE MISSING | 16 | M51 |
| 573 | TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN | 16 | MA32 |
| 574 | SERVICE DATES ARE NOT IN SAME MONTH | 16 | N74 |
| 575 | SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE | 16 | N341 |
| 576 | CLAIM HAS THIRD-PARTY PAYMENT | 23 | MA92 |
| 581 | SPAN THRU DATE LESS THAN SPAN FROM DATE | 16 | |
| 589 | ADJUSTMENT HAS AUTO DENIAL | 45 | M85 |
| 595 | MANUALLY SUSPEND FOR REVIEW | 45 | M85 |
| 596 | FILE SEPARATE CLAIMS FOR DIFFERENT YEARS | 129 | N61 |
| 599 | ATTACHMENT CONTROL NUMBER MISSING | 16 | N3 |
| 602 | UNITS NOT EQUAL TO TEETH BILLED | 16 | M53 |
| 603 | ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM. | 16 | N3 |
| 605 | FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24 | 16 | |
| 606 | INVALID OTHER PAYER DATE | 125 | N307 |
| 607 | ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM. | 16 | N3 |
| 609 | PART A CROSSOVER SPANS 20020501 | 45 | |
| 643 | INVALID OTHER COVERAGE CODE | 16 | N245 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 652 | MISSING OR INVALID OTHER PAYER COVERAGE TYPE | 16 | N245 |
| 675 | ADJ - RECIPIENT ID NOT SUBMITTED | 16 | N382 |
| 676 | ADJ - PROVIDER ID NOT SUBMITTED | 16 | N77 |
| 677 | ADJ - ORIGINAL ICN NOT FOUND | 107 | M47 |
| 678 | ADJ - ORIGINAL ICN NOT SUBMITTED | 107 | M47 |
| 679 | ADJ - REQUEST RECIPIENT ID NOT FOUND | 16 | N382 |
| 680 | ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL | 16 | N152 |
| 681 | ADJ - ORIGINAL ICN NOT FOUND | 107 | M47 |
| 682 | ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED | 16 | |
| 683 | ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS | 16 | |
| 684 | ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL | 16 | N152 |
| 685 | ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS | 16 | N142 |
| 686 | ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE | 16 | N152 |
| 687 | CANNOT ADJUST THIS CLAIM DUE TO PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT | 16 | M56 |
| 688 | CANNOT ADJUST THIS CLAIM DUE TO PHP TERMINATION. VOID THIS CLAIM AND RESUBMIT | 16 | |
| 800 | DETAIL RATE NOT NUMERIC | 125 | M79 |
| 801 | DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT | 125 | M79 |
| 803 | DATED EXCEED SOBRA/QMB ELIGIBILITY | 141 | N61 |
| 805 | NONCOVERED CHARGE IS NOT NUMERIC | 96 | M79 |
| 806 | MEDICARE PAID AMOUNT MISSING OR INVALID | 125 | MA64 |
| 807 | INVALID TPL ADJUDICATION DATE | 16 | N307 |
| 808 | TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE | 16 | N307 |
| 809 | VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS | 16 | MA35 |
| 810 | INVALID DEDUCTIBLE AMT - SKILLED NURSING FACILITY | 1 | |
| 811 | HEADER FROM DATE OF SERVICE > ICN DATE | 125 | M52 |
| 812 | ADMIT DATE IS GREATER THAN ICN DATE | 125 | MA40 |
| 813 | MEDICARE PAID DATE > ICN DATE | 16 | N307 |
| 814 | DETAIL TO DATE OF SERVICE > ICN DATE | 125 | M59 |
| 815 | SURGICAL ICD9 REQUIRES OPERATING PHYSICIAN | 125 | N262 |
| 816 | COINSURANCE DAYS NOT NUMERIC | 2 | MA34 |
| 817 | INVALID COINSURANCE DAYS | 2 | MA34 |
| 818 | LIFETIME RESERVE DAYS NOT NUMERIC | 125 | MA35 |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 819 | LIFETIME RESERVE DAYS > MAX ALLOWED | 125 | MA35 |
| 820 | FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR | 125 | N61 |
| 821 | NON-COVERED DAYS MISSING OR NOT NUMERIC | 78 | MA33 |
| 822 | SURGICAL REVENUE CODE REQUIRES ICD9 SURGERY CODE | 125 | M67 |
| 823 | RECIPIENT CHECK DIGIT IS MISSING OR INVALID | 125 | N382 |
| 824 | UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION | B5 | |
| 825 | MEDICARE ALLOWED AMOUNT MISSING OR INVALID | 125 | N219 |
| 826 | TYPE OF BILL INVALID FOR CLAIM TYPE | 16 | MA30 |
| 827 | NON COVERED AMOUNT IS GREATER THAN COVERED AMOUNT | 125 | |
| 830 | MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW | 125 | N219 |
| 831 | MEDICARE HDR PAID AMNT NOT EQUAL SUM OF DTL PAID | 125 | |
| 832 | OTHER PAYER AMOUNT PAID QUALIFIER INVALID | 16 | |
| 833 | CO-INSURANCE AMOUNT DOES NOT BALANCE | 2 | |
| 835 | MEDICARE DATA NOT FOUND - FORMAT ERROR | 16 | |
| 836 | MEDICARE PAID, DEDUCTIBLE AMOUNTS INVALID - BOTH CANNOT BE ZERO **OR** MEDICAR | 16 | M49 |
| 900 | PROVIDER TYPE SPECIALITY GROUP NOT FOUND | B7 | MA112 |
| 901 | GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE | B7 | MA112 |
| 902 | PROCEDURE CODE GROUP NOT FOUND | 16 | N55 |
| 903 | GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T | 16 | M77 |
| 904 | GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE | 16 | |
| 905 | GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL | 16 | N188 |
| 906 | GROUP NUMBER NOT FOUND IN ICD-9 GROUP TABLE | 16 | M51 |
| 907 | GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE | B7 | |
| 908 | GROUP NUMBER NOT FOUND IN VALUE GROUP TABLE | B7 | |
| 909 | GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE | 16 | M76 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 910 | BENEFIT PLAN GROUP NOT FOUND | 16 | |
| 911 | INTERNAL PROCESSING ERROR - CONTACT HP | 16 | |
| 912 | INTERNAL ERROR-DOLLAR DISTRIBUTION | 16 | |
| 913 | GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE | 16 | M50 |
| 914 | GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE | 16 | MA30 |
| 915 | GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE | B7 | MA112 |
| 916 | GROUP NOT FOUND IN PROVIDER GROUP TABLE | B7 | MA112 |
| 917 | GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE | 16 | M51 |
| 918 | TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR | 16 | N75 |
| 919 | GROUP NUMBER NOT FOUND IN AID CODE TABLE | 16 | N216 |
| 920 | DRUG THERAPEUTIC CLASS GROUP NOT FOUND | 16 | |
| 921 | GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE | B7 | MA112 |
| 922 | TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE | 1 | |
| 923 | RULE OVERLAP IDENTIFIED | 16 | |
| 1000 | NO PAY-TO PROVIDER RECORD | 16 | N279 |
| 1001 | BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE | B7 | N257 |
| 1002 | PERFORMING PROV NOT ELIGIBLE FOR DOS | B7 | N277 |
| 1003 | PROVIDER INELIGIBLE ON DATE OF SERVICE | B7 | N95 |
| 1007 | RENDERING PROVIDER IDENTIFIER NOT ON FILE | 16 | N290 |
| 1010 | PERFORMING PROVIDER NOT IN BILLING GROUP | 16 | N55 |
| 1018 | CLINIC RATE NOT ON FILE FOR HOSPITAL | 16 | N65 |
| 1019 | MULTIPLE RATES FOR LEVEL OF CARE - RATE CHANGE OVERLAPS SERVICE DATES; SPLIT BI | 16 | |
| 1024 | BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV | 38 | N31 |
| 1027 | REFERRING PROVIDER NOT FOUND | 100 | N31 |
| 1032 | PROVIDER TYPE - CLAIM INPUT CONFLICT | 125 | N34 |
| 1049 | BILLING PROVIDER ENROLLMENT STATUS INVALID | B7 | |
| 1050 | SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER | 38 | N286 |
| 1051 | RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR) | 16 | N277 |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 1052 | OTHER-2 (REFERRING) PROVIDER ID NOT ON FILE - DTL | 16 | N286 |
| 1053 | OTHER-1 (OPERATING) PROVIDER ID NOT ON FILE - DTL | 16 | N262 |
| 1055 | DTL REFERRING PROV NOT ON FILE | 16 | N286 |
| 1058 | NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM | 16 | |
| 1065 | PROVIDER NAME MISMATCH | 125 | N279 |
| 1803 | BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER | 125 | N55 |
| 1804 | VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER | 125 | N55 |
| 1805 | BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS | 125 | N95 |
| 1806 | EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS UNDER | 6 | |
| 1807 | CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE | 16 | N34 |
| 1812 | RECIPIENT / ADMIT AGE GREATER THAN 21 | 6 | |
| 1814 | BILLING PROVIDER NOT VALID FOR DATES OF SERVICE | B7 | |
| 1815 | PERF PROV ENROLL STATUS NOT VALID FOR DOS | 16 | N290 |
| 1816 | MATERNITY CARE MUST BE PERFORMED BY DISTRICT PROV | 38 | |
| 1817 | MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS | 8 | N95 |
| 1818 | WAIVER PROVIDER MISMATCH | 38 | |
| 1819 | INVALID POS FOR FQHC PROVIDER | 5 | M77 |
| 1820 | PATIENT FIRST CLAIM REQUIRES A REFERRAL | 38 | N286 |
| 1821 | MEDICAL LOCKIN - RECIPIENT LOCKED IN TO OTHER PROVIDER | 38 | |
| 1822 | MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES | 38 | |
| 1823 | WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES | 38 | |
| 1824 | LTC ASSIGNMENT DATES OVERLAP CLAIM DATES | 38 | |
| 1825 | COBA DENIAL - DO NOT CROSSOVER | 16 | N34 |
| 1826 | SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE | 16 | N95 |
| 1900 | TAXONOMY IS INVALID BILLING PROVIDER | 16 | N255 |
| 1901 | TAXONOMY IS INVALID PREFORMING PROVIDER | 16 | N288 |
| 1902 | TAXONOMY IS INVALID REFERRING PROVIDER | 45 | |
| 1903 | TAXONOMY IS INVALID: FACILITY PROVIDER | 45 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 1905 | TAXONOMY IS INVALID: OTHER PROVIDER 2 | 45 | |
| 1906 | TAXONOMY IS NOT VALID FOR BILLING PROVIDER | 16 | N255 |
| 1907 | TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER | 16 | N288 |
| 1908 | TAXONOMY IS NOT VALID FOR REFERRING PROVIDER | 45 | |
| 1909 | TAXONOMY IS NOT VALID FOR FACILITY PROVIDER | 45 | |
| 1911 | TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2 | 45 | |
| 1912 | TAXONOMY IS MISSING: BILLING PROVIDER | 16 | N255 |
| 1913 | TAXONOMY IS MISSING: PERFORMING PROVIDER | 16 | N288 |
| 1914 | TAXONOMY IS MISSING: REFERRING PROVIDER | 45 | |
| 1915 | TAXONOMY IS MISSING: FACILITY PROVIDER | 45 | |
| 1917 | TAXONOMY IS MISSING: OTHER PROVIDER 2 | 45 | |
| 1918 | TAXONOMY IS INVALID: DTL OTHER PROVIDER 2 | 45 | |
| 1919 | TAXONOMY IS INVALID: DTL PERFORMING PROVIDER | 16 | N288 |
| 1920 | TAXONOMY IS INVALID: DTL REFERRING PROVIDER | 45 | |
| 1921 | TAXONOMY IS MISSING: DTL PERFORMING PROVIDER | 16 | N288 |
| 1922 | TAXONOMY IS MISSING: DTL REFERRING PROVIDER | 45 | |
| 1923 | TAXONOMY IS MISSING: DTL OTHER PROVIDER 2 | 45 | |
| 1924 | TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2 | 45 | |
| 1925 | TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV | 16 | N288 |
| 1926 | TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER | 45 | |
| 1927 | BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N | 206 | N257 |
| 1928 | NPI REQUIRED HEALTHCARE=Y PREMING PROV | 206 | N290 |
| 1929 | NPI REQUIRED HEALTHCARE=Y REFERRING PROV | 45 | |
| 1930 | NPI REQUIRED HEALTHCARE=Y FACILITY PROV | 45 | |
| 1931 | NPI REQUIRED HEALTHCARE=Y RENDERING PROV | 206 | N290 |
| 1932 | NPI REQUIRED: OTHER PROVIDER 2 (HEALTHCARE) | 45 | |
| 1933 | NPI REQUIRED: DTL OTHER PROVIDER 2 (HEALTHCARE) | 45 | |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 1934 | DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV | 206 | N290 |
| 1935 | DTL NPI REQUIRED HEALTHCARE=Y REFERRING PROV | 45 | |
| 1960 | NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE) | 16 | N253 |
| 1961 | NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE) | 16 | N262 |
| 1962 | NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE) | 16 | N286 |
| 1974 | TAXONOMY IS INVALID: DTL PERFORMING PROVIDER | 16 | N288 |
| 1975 | TAXONOMY IS INVALID: DTL REFERRING PROVIDER | 16 | N284 |
| 1976 | TAXONOMY IS INVALID: DTL OTHER PROVIDER 2 | 16 | N94 |
| 1977 | TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2 | 16 | N94 |
| 1978 | TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV | 16 | N288 |
| 1979 | TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER | 16 | N284 |
| 1980 | TAXONOMY IS NOT VALID FOR BILLING PROVIDER | 16 | N255 |
| 1981 | TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER | 16 | N288 |
| 1982 | TAXONOMY IS NOT VALID FOR REFERRING PROVIDER | 16 | N284 |
| 1983 | TAXONOMY IS NOT VALID FOR FACILITY PROVIDER | 16 | N94 |
| 1984 | TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2 | 16 | N94 |
| 1985 | TAXONOMY IS INVALID: BILLING PROVIDER | 16 | N255 |
| 1986 | TAXONOMY IS INVALID: PERFORMING PROVIDER | 16 | N288 |
| 1987 | TAXONOMY IS INVALID: REFERRING PROVIDER | 16 | N284 |
| 1988 | TAXONOMY IS INVALID: FACILITY PROVIDER | 16 | N94 |
| 1989 | TAXONOMY IS INVALID: OTHER PROVIDER 2 | 16 | N94 |
| 1996 | THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM. | B7 | |
| 1999 | PROVIDER ID IS INVALID, IS NOT ON FILE OR NAME/NUMBER DISAGREE. | B7 | |
| 2003 | ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN | 26 | N30 |
| 2011 | PHARMCY MEDICAL/NON-MEDICAL SUPPL. AND ROUTINE DME | 92 | |
| 2017 | RECIPIENT SERVICES COVERED BY HMO PLAN | 24 | M100 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 2045 | ITEM NOT PAYABLE IN LONG TERM CARE FACILITY | 96 | N30 |
| 2054 | UNABLE TO DETERMINE FUND CODE - DETAIL | 16 | |
| 2055 | UNABLE TO DETERMINE AID CAT OR COUNTY | 16 | |
| 2057 | RECIPIENT PARTIALLY ELIGIBLE - HEADER | 141 | N61 |
| 2077 | RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES | 141 | N61 |
| 2500 | RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT) | 109 | |
| 2501 | RECIPIENT COVERED BY MEDICARE A (WITH ATTACHMENT) | 109 | |
| 2502 | RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT) | 109 | |
| 2503 | RECIPIENT COVERED BY MEDICARE B (WITH ATTACHMENT) | 109 | |
| 2504 | FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER | 22 | N4 |
| 2505 | RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT) | 22 | N4 |
| 2506 | INSURANCE DENIAL REQUIRED | 129 | N4 |
| 2507 | THIS PATIENT HAS TWO COVERAGE TYPES | 22 | N4 |
| 2508 | RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY) | 22 | N4 |
| 2509 | FILE CLAIM WITH MEDICARE | 109 | N104 |
| 2510 | HMO CO-PAY/RECIPIENT HAS TPL | 22 | N4 |
| 2511 | HMO CO-PAY/RECIPIENT HAS MEDICARE | 22 | |
| 2512 | HMO CO-PAY/NO TPL OR MEDICARE COVERAGE | 22 | |
| 2514 | RECIPIENT COVERED BY MEDICARE(A AND B), NO MED D) | 109 | |
| 2550 | RECIPIENT ENROLLED IN MEDICARE ADVANTAGE PLAN | 109 | |
| 2590 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 | |
| 2591 | SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE | 16 | |
| 2800 | STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME | 226 | N288 |
| 2801 | HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN | 226 | N288 |
| 2802 | ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS. | 226 | N288 |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 2804 | DETAILS COVERED BY MORE THAN ONE PLAN CODE | 141 | N61 |
| 2805 | DOS PRIOR TO DOB | 14 | |
| 2806 | PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX | 16 | |
| 2807 | COBA-NO MEDICAID ID FOR MEDICARE ID | 31 | N382 |
| 2808 | COBA - MEDICARE ID NOT ON FILE | 31 | N382 |
| 3018 | STOP LOSS THRESHOLD REACHED - ENCOUNTER CLAIMS | 45 | M100 |
| 3019 | PA CUTBACK PERFORMED | 45 | N123 |
| 3021 | DRG REQUIRES PA | 92 | |
| 3100 | CLAIM AND PA PRESCRIBING PROV DON'T MATCH | 16 | M100 |
| 3101 | ONLINE PA DENIED BY HID, NDC REQUIRES PA | 16 | |
| 3102 | ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM | 16 | |
| 3103 | ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS | 16 | |
| 3104 | PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES | 15 | M62 |
| 3105 | DAW 1 - BRAND WITH GENERIC EQUIVALENT REQUIRES OVERRIDE | 16 | |
| 3300 | NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH | B5 | M76 |
| 3301 | BILL EMERGENCY PROCEDURE/REVENUE TOGETHER | 199 | |
| 3302 | PROCEDURE AND REVENUE CODE COMBINATION NOT VALID | B5 | M50 |
| 3304 | NON-COVERED SVC FOR RECIPIENT < 6 MONTHS OLD | 6 | |
| 3306 | HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT | 125 | |
| 3307 | FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT | B5 | N59 |
| 3309 | PROCEDURE CODE - TYPE OF BILL RESTRICTION | 5 | MA30 |
| 3310 | DISPENSING FEE NOT LOCATED | 16 | |
| 3311 | REFILL NUMBER EXCEEDS MAXIMUM ALLOWED | 16 | |
| 3312 | DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY | 16 | |
| 3313 | NDC DRUG, PRODUCT IS NOT PREFERRED | 16 | M62 |
| 3314 | PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP | 16 | M97 |
| 3315 | NURSERY DAYS EXCEED LIMIT | 119 | N362 |
| 3316 | PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID | 16 | M119 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 3317 | CLAIM QUANTITY EXCEEDS NDC MAX UNITS | 125 | |
| 3318 | NDC NOT APPROPRIATE FOR RECIPIENT AGE. | 6 | |
| 3319 | NDC IS INAPPROPRIATE FOR RECIPIENT SEX | 7 | |
| 3320 | SERVICE INCLUDED IN FACILITY FEE | 16 | |
| 3599 | MANUAL PRICING REQUIRED | 101 | |
| 3800 | SERVICE COVERAGE HAS NOT BEEN DETERMINED | 133 | |
| 3997 | BPA-RR-DRG - ANY HDR DIAGNOSIS RESTRICTION | 16 | |
| 3998 | BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 3999 | BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4000 | MORE THAN TWO SURGICAL UNITS ON THE CLAIM | 45 | |
| 4001 | BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION | 12 | M76 |
| 4002 | BPA-RP-NDC - NO COVERAGE | 96 | M119 |
| 4004 | NDC IS NOT ON FILE | 96 | M119 |
| 4005 | SUBMITTED TO ALLOWED EXCEEDS PERCENT | 125 | M54 |
| 4006 | ALLOWED TO SUBMITTED EXCEEDS PERCENT | 125 | M54 |
| 4009 | ALLOWED TO SUBMITTED EXCEEDS PERCENT | 125 | M54 |
| 4010 | MODIFIER REQUIRES MEDICAL REVIEW | 133 | |
| 4011 | INVALID MODIFIER COMBINATION | 4 | |
| 4013 | PROCEDURE CODE IS NO LONGER VALID | 96 | M51 |
| 4014 | NO PRICING SEGMENT IS ON FILE. | 133 | N65 |
| 4015 | PASARR ASSESSMENT PROCEDURE FOR REVIEW | 92 | |
| 4016 | BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION | 12 | M76 |
| 4017 | BPA-RP-DRG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4018 | BPA-RP-DRG - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4021 | BPA-RP-PROC - NO COVERAGE | 96 | M51 |
| 4023 | BPA-RP-NDC - GENDER RESTRICTION | 16 | |
| 4025 | BPA-RP-NDC - AGE RESTRICTION | 16 | |
| 4026 | BPA-RP-NDC - MAX UNIT RESTRICTION | 16 | |
| 4028 | BPA-RP-DIAG - GENDER RESTRICTION | 10 | |
| 4029 | BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4030 | BPA-RP-DIAG - AGE RESTRICTION | 9 | |
| 4031 | BPA-PC-DIAG - GENDER RESTRICTION | 10 | |
| 4032 | PROCEDURE CODE IS MISSING/NOT ON FILE | 96 | M51 |
| 4034 | BPA-RP-PROC - AGE RESTRICTION | 6 | |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4035 | BPA-RP-PROC - GENDER RESTRICTION | 7 | |
| 4036 | BPA-RP-PROC - PLACE OF SERVICE RESTRICTION | 5 | |
| 4044 | BPA-RR-DIAG - NO RULE FOR ASSOC AGE | 9 | |
| 4045 | BPA-RR - NO RULE FOR BENEFIT PLAN | 16 | |
| 4046 | DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE | 96 | N56 |
| 4053 | PRINCIPAL PROCEDURE CODE NOT ON FILE | 16 | |
| 4054 | FIRST OTHER PROCEDURE CODE NOT ON FILE | 16 | N65 |
| 4055 | SECOND OTHER PROCEDURE CODE NOT ON FILE | 16 | N65 |
| 4056 | THIRD OTHER PROCEDURE CODE NOT ON FILE | 16 | N65 |
| 4057 | FOURTH OTHER PROCEDURE CODE NOT ON FILE | 16 | N65 |
| 4058 | FIFTH OTHER PROCEDURE CODE NOT ON FILE | 16 | N65 |
| 4059 | REVENUE CODE NOT ON FILE | 16 | M50 |
| 4061 | BPA-RR - NO RULE FOR CLAIM TYPE | 16 | N34 |
| 4062 | BPA-RR - NO RULE FOR COND CODE | 16 | M44 |
| 4064 | BPA-RP-ICD9 - GENDER RESTRICTION | 16 | MA39 |
| 4068 | BPA-RR - NO RULE CURR BILL PROV CONTRACT | B7 | |
| 4070 | BPA-RR-PROC - MODIFIER RESTRICTION | 4 | |
| 4072 | BPA-RR-DRG - NO RULE FOR ADMIT OR HDR DIAGNOSIS | 16 | |
| 4073 | BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION | 16 | MA63 |
| 4075 | BPA-RP-ICD9 - FAMILY PLANNING IND RESTRICTION | 16 | M51 |
| 4076 | BPA-RP-NDC - FAMILY PLANNING IND RESTRICTION | 16 | |
| 4077 | NON-COVERED REVENUE CODE | 16 | M50 |
| 4084 | SUBMITTED TO ALLOWED EXCEEDS PERCENT | 125 | M54 |
| 4089 | MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED | 96 | M100 |
| 4093 | BPA-RP-DIAG - DIAG ROLE RESTRICTION | 16 | M76 |
| 4094 | BPA-PC-REV - PROV COUNTY RESTRICTION | B7 | |
| 4095 | NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL | 45 | |
| 4097 | INVALID/MISSING MODIFIER FOR THIS PROCEDURE | 4 | M78 |
| 4099 | DRG NOT ON FILE | 92 | |
| 4104 | BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION | 16 | M51 |
| 4106 | BPA-RP-REV - FAMILY PLANNING IND RESTRICTION | 16 | M50 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 4109 | BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION | 16 | M76 |
| 4112 | BPA-PC-ICD9 - FAMILY PLANNING IND RESTRICTION | 16 | M51 |
| 4113 | UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY | 92 | |
| 4114 | PRICING BEING REVIEWED | 133 | M100 |
| 4117 | BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION | 16 | M119 |
| 4118 | BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION | 16 | M51 |
| 4120 | ORAL CAVITY DESIGNATION CODE INVALID | 16 | N346 |
| 4127 | CANNOT PRIORITIZE RECIPIENT'S PROGRAMS | 133 | |
| 4128 | ICD9 PROCEDURE 7-24 NOT ON FILE | 16 | |
| 4130 | PAYER HIERARCHY NOT FOUND | A1 | M56 |
| 4131 | NO BENEFIT PLANS ASSOCIATED TO PAYER | B7 | |
| 4132 | DRG GROUPER UNABLE TO ASSIGN DRG FOR PRICING | 92 | |
| 4136 | BPA-RP-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M51 |
| 4138 | BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M119 |
| 4140 | BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M51 |
| 4141 | BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | M51 |
| 4142 | BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M50 |
| 4143 | BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | M50 |
| 4144 | BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | M76 |
| 4145 | BPA-PC-DRG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4146 | BPA-PC-DRG - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4149 | BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M51 |
| 4150 | BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | M51 |
| 4151 | BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | M50 |
| 4152 | BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION | 16 | M50 |
| 4154 | BPA-PC-REV - FAMILY PLANNING IND RESTRICTION | 16 | M50 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4155 | BPA-RR-PROC - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4157 | BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION | B7 | M76 |
| 4158 | BPA-PC-DRG - CURR PROV CONTRACT RESTRICTION | 16 | |
| 4159 | BPA-PC-ICD9 - CURR PROV CONTRACT RESTRICTION | B7 | M51 |
| 4160 | BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION | B7 | M119 |
| 4161 | BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION | B7 | M51 |
| 4162 | BPA-PC-REV - CURR PROV CONTRACT RESTRICTION | B7 | M50 |
| 4164 | INACTIVE DRUG | 96 | |
| 4165 | Max Day Restriction for Covered NDC | 16 | |
| 4166 | BPA-RR-NDC - NO RULE FOR BENEFIT PLAN | 16 | M119 |
| 4167 | BPA-RR-REV - NO RULE FOR BENEFIT PLAN | 16 | M50 |
| 4177 | BPA-PC-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | N95 |
| 4190 | BPA-RP-DRG - ANY HDR DIAGNOSIS RESTRICTION | 16 | |
| 4191 | BPA-PC-DRG - ANY HDR DIAGNOSIS RESTRICTION | 16 | |
| 4192 | BPA-RP-DRG - OTHER DTL DIAG RESTRICTION | 16 | |
| 4194 | BPA-RP-PROC - OTHER DTL DIAG RESTRICTION | 16 | M51 |
| 4200 | CLAIM PRICED AT ZERO | 45 | |
| 4203 | DENIAL MODIFIER SUBMITTED ON CLAIM | B7 | |
| 4207 | CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE | B7 | MA120 |
| 4208 | CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD | B7 | MA120 |
| 4210 | BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4211 | INVALID TOOTH NUMBER FOR THIS PROCEDURE | 16 | N37 |
| 4212 | BILLING OUT OF CLIA CERTIFICATE TYPE | B7 | MA120 |
| 4219 | BPA-RR-REV - NO RULE FOR TYPE OF BILL | 16 | MA30 |
| 4224 | BPA-RP-PROC - QUANTITY RESTRICTION | 16 | N362 |
| 4225 | INVALID INPATIENT REVENUE CODE | 16 | M50 |
| 4226 | DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION | 16 | M81 |
| 4227 | BPA-RP-REV - NO COVERAGE | 16 | M50 |
| 4231 | BPA-PC-NDC - MAX UNIT RESTRICTION | 16 | |
| 4233 | DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION | 16 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4236 | INVALID USE OF EMERGENCY DIAGNOSIS CODE | 16 | |
| 4237 | INVALID TYPE OF LEAVE | 16 | |
| 4240 | THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE | 16 | |
| 4244 | BPA-RP-DIAG - NO COVERAGE | 16 | M76 |
| 4245 | FOURTH MODIFIER INVALID FOR DATE OF SERVICE | 4 | |
| 4246 | ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE | 45 | M78 |
| 4250 | BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF | 16 | N95 |
| 4251 | DECIMAL UNITS NOT BILLABLE FOR PROCEDURE. | 16 | M53 |
| 4252 | DIAGNOSIS CODE 10-24 NOT ON FILE | 16 | M64 |
| 4254 | BPA-RP-REV - AGE RESTRICTION | 6 | M50 |
| 4255 | BPA-PC-DRG - ADMIT DIAG RESTRICTION | 16 | |
| 4256 | BPA-RP-PROC - MODIFIER RESTRICTION | 4 | |
| 4257 | BPA-PC-PROC - MODIFIER RESTRICTION | 4 | |
| 4258 | BPA-PC-DRG - OCCURRENCE CODE RESTRICTION | 16 | |
| 4260 | NDC REQUIRED FOR PROCEDURE | 16 | M119 |
| 4261 | INVALID UNIT OF MEASURE VALUE | 16 | |
| 4262 | NDC QUANTITY UNITS IS NOT NUMERIC | 16 | |
| 4263 | NDC QUANTITY UNITS IS ZERO | 16 | |
| 4264 | NDC NOT ON THE DRUG FILE | 16 | M119 |
| 4265 | INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC | 16 | M119 |
| 4266 | PRIMARY NDC NO LONGER ACTIVE ON DATE OF SVC | 16 | M119 |
| 4267 | SECONDARY NDC NO LONGER ACTIVE ON DATE OF SVC | 16 | M119 |
| 4268 | PRIMARY NDC NOT REBATABLE ON THE DATE OF SERVICE | 16 | M119 |
| 4269 | SECONDARY NDC NOT REBATABLE ON THE DATE OF SERVICE | 16 | M119 |
| 4270 | NDC RATED LESS THAN EFFECTIVE | 16 | M119 |
| 4271 | NDC REQUIRED FOR PROCEDURE | 16 | M119 |
| 4272 | NDC OBSOLETE OR INVALID ON THE DATE OF SERVICE | 16 | M119 |
| 4273 | INVALID NDC QUALIFIER CODE, MUST EQUAL N4 | 16 | M119 |
| 4274 | INVALID PRESCRIPTION QUALIFIER CODE, MUST EQUAL XZ | 16 | |
| 4275 | DRUG UNIT PRICE IS NOT NUMERIC | 16 | |
| 4276 | DRUG UNIT PRICE IS ZERO | 16 | |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4310 | BPA-PC-PROC - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4311 | BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4312 | BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION | 16 | MA63 |
| 4313 | BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION | 16 | M64 |
| 4314 | BPA-RP-DIAG - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4315 | BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4316 | BPA-PC -ANY DTL DIAG RESTRICTION | 16 | M64 |
| 4317 | BPA-PC-ICD9 - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4318 | BPA-PC-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4319 | BPA-PC-ICD9 - ANY HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4320 | BPA-PC-REV - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4321 | BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4322 | BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4361 | BPA - DIAGNOSIS RESTRICTION | 16 | M76 |
| 4362 | BPA-PC-DIAG - TYPE OF BILL RESTRICTION | 16 | MA30 |
| 4363 | BPA-PC-DRG - TYPE OF BILL RESTRICTION | 16 | MA30 |
| 4364 | BPA-PC-ICD9 - TYPE OF BILL RESTRICTION | 16 | MA30 |
| 4371 | BPA-RP-PROC - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4372 | BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION | 16 | M64 |
| 4373 | BPA-RP-NDC - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4374 | BPA-RP-REV - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4376 | BPA-RP-ICD9 - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4500 | BPA-RR-NDC - ALGI RESTRICTION | 16 | |
| 4501 | BPA-RR-NDC - NO RULE FOR DISP AS WRITTEN IND | 16 | |
| 4502 | BPA-RP-PROC - EPSDT REFERRAL RESTRICTION | 16 | |
| 4503 | BPA-PC-PROC - EPSDT REFERRAL RESTRICTION | 16 | |
| 4504 | BPA-RP-NDC - ALGI RESTRICTION | 16 | |
| 4505 | BPA-RR-PROC - NO RULE FOR URBAN/RURAL IND | 16 | |
| 4506 | BPA-PC-DIAG - PERF PROV ALL PT/PS RESTRICTION | 16 | |
| 4508 | BPA-PC-PROC - PERF PROV ALL PT/PS RESTRICTION | 16 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 4509 | BPA-PC-REV - PERF PROV ALL PT/PS RESTRICTION | 16 | |
| 4511 | BPA-RP-DIAG - PERF PROV ALL PT/PS RESTRICTION | 16 | |
| 4514 | BPA-RP-PROC - PERF PROV ALL PT/PS RESTRICTION | 16 | |
| 4515 | BPA-RP-REV - PERF PROV ALL PT/PS RESTRICTION | 16 | |
| 4516 | BPA-PC-DIAG - BILL PROV ALL PT/PS RESTRICTION | 16 | |
| 4517 | BPA-PC-NDC - BILL PROV ALL PT/PS RESTRICTION | 16 | |
| 4518 | BPA-PC-ICD9 - BILL PROV ALL PT/PS RESTRICTION | 16 | |
| 4519 | BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION | 16 | M51 |
| 4520 | BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION | 16 | M50 |
| 4521 | BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION | 16 | M76 |
| 4522 | BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION | 16 | M119 |
| 4523 | BPA-RP-ICD9 - BILL PROV ALL PT/PS RESTRICTION | 16 | M76 |
| 4524 | BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION | 16 | M51 |
| 4525 | BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION | 16 | M50 |
| 4526 | BPA-PC-PROC - PROV COUNTY RESTRICTION | B7 | |
| 4527 | BPA-PC-NDC - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4529 | BPA-RP-REV - PROV COUNTY RESTRICTION | B7 | M50 |
| 4530 | BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION | 16 | M64 |
| 4532 | BPA-RR-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4533 | BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4534 | BPA-RP-DRG - EMERGENCY DIAGNOSIS RESTRICTION | 16 | |
| 4535 | BPA-RP-ICD9 - EMERGENCY DIAGNOSIS RESTRICTION | 16 | M76 |
| 4536 | BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION | 16 | M76 |
| 4538 | BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION | 16 | M76 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 4539 | BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION | 16 | M76 |
| 4540 | BPA-PC-PROC - MIN UNIT RESTRICTION | 16 | M53 |
| 4541 | BPA-RP-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4542 | BPA-RP-DRG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4545 | BPA-RP-PROC - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4546 | BPA-RP-REV - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4547 | BPA-PC-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4548 | BPA-PC-DRG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4551 | BPA-PC-PROC - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4552 | BPA-PC-REV - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4553 | BPA-RR-DIAG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4554 | BPA-RR-DRG - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4556 | BPA-RR-NDC - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4557 | BPA-RR-PROC - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4558 | BPA-RR-REV - REFER PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4559 | BPA-RP-DRG - SECONDARY HDR DIAG RESTRICTION | 16 | |
| 4560 | BPA-RP-ICD9 - SECONDARY HDR DIAG RESTRICTION | 16 | M64 |
| 4561 | BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION | 16 | M64 |
| 4562 | BPA-RP-REV - GENDER RESTRICTION | 16 | MA39 |
| 4563 | BPA-RR - NO RULE CURR PERF PROV CONTRACT | B7 | |
| 4564 | BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION | 16 | M64 |
| 4565 | BPA-RR-ICD9 - HDR SECONDARY DIAG RESTRICTION | 16 | M64 |
| 4566 | BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION | 16 | M64 |
| 4580 | BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP | 16 | MA63 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4581 | BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP | 16 | MA63 |
| 4711 | BPA-PC-DIAG - AGE RESTRICTION | 9 | |
| 4712 | BPA-PC-DRG - AGE RESTRICTION | 16 | |
| 4713 | BPA-PC-NDC - AGE RESTRICTION | 16 | |
| 4714 | BPA-PC-PROC - AGE RESTRICTION | 6 | |
| 4715 | BPA-PC-REV - AGE RESTRICTION | 6 | |
| 4716 | BPA-PC-ICD9 - AGE RESTRICTION | 16 | M76 |
| 4721 | BPA-RP-DRG - ADMIT DIAG RESTRICTION | 6 | |
| 4722 | BPA-RP-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | |
| 4723 | BPA-RP-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA36 |
| 4724 | BPA-RP-ICD9 - ANY HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4726 | BPA-RP-ICD9 - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4731 | BPA-RP-PROC - ANY DTL DIAG RESTRICTION | 16 | M64 |
| 4732 | BPA-RP-REV - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4733 | BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4734 | BPA-PC-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA36 |
| 4736 | BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4741 | BPA-RP-PROC - ADMIT DIAG RESTRICTION | 16 | MA65 |
| 4742 | BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION | 16 | MA63 |
| 4743 | BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION | 16 | M64 |
| 4744 | BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION | 16 | M64 |
| 4745 | BPA-RP-PROC - DIAGNOSIS RESTRICTION | 16 | M64 |
| 4746 | BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION | 16 | MA63 |
| 4747 | BPA-PC-ICD9 - HDR SECONDARY DIAG RESTRICTION | 16 | M64 |
| 4748 | BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION | 16 | M64 |
| 4751 | BPA-PC-REV - TYPE OF BILL RESTRICTION | 16 | MA30 |
| 4755 | BPA-PC-PROC - CURRENT BENEFIT PLAN RESTRICTION | 16 | |
| 4756 | BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION | 16 | M76 |
| 4757 | BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION | 16 | M50 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4762 | BPA-PC-ICD9 - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4765 | BPA-RP-ICD9 - NO COVERAGE | 16 | M64 |
| 4766 | BPA-RP-ICD9 - AGE RESTRICTION | 9 | |
| 4767 | BPA-RP-ICD9 - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4775 | BPA-PC-NDC - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4776 | BPA-PC-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION | 16 | |
| 4801 | BPA-PC-PROC - NO CONTRACT | 16 | M51 |
| 4802 | BPA-PC-DIAG - NO CONTRACT | 16 | M76 |
| 4803 | BPA-PC-NDC - NO CONTRACT | 16 | |
| 4804 | BPA-PC-REV - NO CONTRACT | 16 | M50 |
| 4805 | BPA-PC-DRG - NO CONTRACT | 16 | |
| 4806 | BPA-PC-ICD9 - NO CONTRACT | 16 | M64 |
| 4821 | BPA-PC-PROC - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4822 | BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION | 16 | M77 |
| 4831 | BPA-RR - NO REIMB RULE | 16 | |
| 4835 | BPA-PC-PROC - OTHER DTL DIAG RESTRICTION | 16 | M64 |
| 4871 | BPA-PC-PROC - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4872 | BPA-PC-DIAG - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4873 | BPA-PC-NDC - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4874 | BPA-PC-REV - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4875 | BPA-PC-DRG - CLAIM TYPE RESTRICTION | 16 | |
| 4876 | BPA-PC-ICD9 - CLAIM TYPE RESTRICTION | 16 | N34 |
| 4881 | BPA-PC-DRG - PLACE OF SERVICE RESTRICTION | 16 | |
| 4882 | BPA-RP-DRG - NO COVERAGE | 16 | |
| 4884 | BPA-RP-DRG - AGE RESTRICTION | 16 | |
| 4886 | BPA-RP-DRG - CLAIM TYPE RESTRICTION | 16 | |
| 4887 | BPA-RP-DRG - PLACE OF SERVICE RESTRICTION | 16 | |
| 4900 | BPA-RP-DIAG - BENEFIT PLAN RESTRICTION | 16 | M76 |
| 4901 | BPA-RP-DIAG - CONDITION CODE RESTRICTION | 16 | M44 |
| 4902 | BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4904 | BPA-RP-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 | |
| 4905 | BPA-RP-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4906 | BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 4910 | BPA-PC-DIAG - BENEFIT PLAN RESTRICTION | 16 | M76 |
| 4911 | BPA-PC-DIAG - CONDITION CODE RESTRICTION | 16 | M44 |
| 4912 | BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4913 | BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR | 16 | M45 |
| 4917 | BPA-PC-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 | |
| 4920 | BPA-RP-DRG - BENE PLAN RESTRICTION | 16 | N208 |
| 4921 | BPA-RP-DRG - CONDITION CODE RESTRICTION | 16 | M44 |
| 4922 | BPA-RP-DRG - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4923 | BPA-PC-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M64 |
| 4927 | BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION | 16 | M76 |
| 4928 | BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION | 16 | M51 |
| 4929 | BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION | 16 | M50 |
| 4930 | BPA-PC-DRG - BENEFIT PLAN RESTRICTION | 16 | N208 |
| 4931 | BPA-PC-DRG - CONDITION CODE RESTRICTION | 16 | M44 |
| 4933 | BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4935 | BPA-RP-DRG - GENDER RESTRICTION | 16 | MA39 |
| 4936 | BPA-PC-DRG - GENDER RESTRICTION | 16 | MA39 |
| 4937 | BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION | 16 | M76 |
| 4938 | BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION | 16 | M51 |
| 4939 | BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION | 16 | M50 |
| 4940 | BPA-RP-ICD9 - BENE PLAN RESTRICTION | 16 | M76 |
| 4941 | BPA-RP-ICD9 - CONDITION CODE RESTRICTION | 16 | M44 |
| 4942 | BPA-RP-ICD9 - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4943 | BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION | 16 | M76 |
| 4944 | BPA-PC-ICD9 - GENDER RESTRICTION | 16 | MA39 |
| 4947 | BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION | 16 | M119 |
| 4948 | BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION | 16 | M51 |
| 4949 | BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION | 16 | M50 |
| 4950 | BPA-PC-ICD9 - BENEFIT PLAN RESTRICTION | 16 | M76 |
| 4951 | BPA-PC-ICD9 - CONDITION CODE RESTRICTION | 16 | M44 |
| 4952 | BPA-PC-ICD9 - OCCURRENCE CODE RESTRICTION | 16 | M45 |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 4953 | BPA-RR-DRG - OTHER DTL DIAG RESTRICTION | 16 | |
| 4960 | BPA-RP-NDC - BENE PLAN RESTRICTION | 16 | M119 |
| 4961 | BPA-RP-PROC - PROV COUNTY RESTRICTION | 16 | M51 |
| 4962 | BPA-PC-NDC - GENDER RESTRICTION | 16 | MA39 |
| 4963 | BPA-PC-PROC - GENDER RESTRICTION | 16 | MA39 |
| 4964 | BPA-PC-REV - GENDER RESTRICTION | 16 | MA39 |
| 4965 | BPA-PC-NDC - BENEFIT PLAN RESTRICTION | 16 | M119 |
| 4966 | BPA-RR - DIAGNOSIS RESTRICTION | 16 | M76 |
| 4970 | BPA-RP-REV - BENEFIT PLAN RESTRICTION | 16 | M50 |
| 4971 | BPA-RP-REV - CONDITION CODE RESTRICTION | 16 | M44 |
| 4972 | BPA-RP-REV - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4973 | BPA-RR-PROC - ANY DTL DIAG RESTRICTION | 16 | M64 |
| 4975 | BPA-PC-REV - BENEFIT PLAN RESTRICTION | 16 | M50 |
| 4976 | BPA-PC-REV - CONDITION CODE RESTRICTION | 16 | M44 |
| 4977 | BPA-PC-REV - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4980 | BPA-RP-PROC - BENEFIT PLAN RESTRICTION | 16 | |
| 4981 | BPA-RP-PROC - CONDITION CODE RESTRICTION | 16 | M44 |
| 4982 | BPA-RP-PROC - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4983 | BPA-RR-DRG - OTHER HDR DIAGNOSIS RESTRICTION | 16 | |
| 4990 | BPA-PC-PROC - BENEFIT PLAN RESTRICTION | 16 | |
| 4991 | BPA-PC-PROC - CONDITION CODE RESTRICTION | 16 | M44 |
| 4992 | BPA-PC-PROC - OCCURRENCE CODE RESTRICTION | 16 | M45 |
| 4993 | BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION | 16 | M76 |
| 4999 | RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP | 96 | N30 |
| 5000 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | |
| 5001 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | |
| 5002 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | |
| 5005 | DENTAL DUPLICATE EXACT | 18 | |
| 5006 | OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BIL | 18 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5010 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5011 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5012 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5013 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5014 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5015 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5016 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5017 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5018 | OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE. | 18 | |
| 5020 | SUSPECT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 | |
| 5021 | EXACT DUPLICATE OF ANOTHER PHARMACY CLAIM. | 18 | |
| 5022 | DUPLICATE RX NUMBER FOR SAME DATE OF SERVICE. | 18 | |
| 5200 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR | B5 | N20 |
| 5201 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR | B5 | N20 |
| 5202 | CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE | B5 | N20 |
| 5203 | CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCE | B5 | N20 |
| 5204 | VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY. | B5 | N20 |
| 5205 | VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY. | B5 | N20 |
| 5206 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE | B5 | N20 |
| 5207 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE | B5 | N20 |
| 5208 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE. | B5 | N20 |
| 5209 | ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE. | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5210 | OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE | B5 | N20 |
| 5211 | OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE | B5 | N20 |
| 5212 | PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518 | B5 | N20 |
| 5213 | PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518 | B5 | N20 |
| 5214 | PROCEDURE CODE NOT ALLOWED ON THE SAME DAY | B5 | N20 |
| 5230 | SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE | 97 | N20 |
| 5231 | SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE | 97 | N20 |
| 5232 | DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH | B5 | N20 |
| 5233 | DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH | B5 | N20 |
| 5234 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | 45 | N59 |
| 5235 | ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED. | 45 | N59 |
| 5236 | QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 5238 | PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS | B5 | N59 |
| 5239 | PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS | B5 | N59 |
| 5240 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY. | 97 | N20 |
| 5241 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY. | 97 | N20 |
| 5260 | BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI | 119 | |
| 5261 | BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AI | 119 | |
| 5262 | PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE | B5 | N20 |
| 5270 | CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5271 | CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 5280 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5281 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5282 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5283 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5284 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5300 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5301 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5302 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5303 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5304 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5305 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5306 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5307 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5308 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5309 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5310 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5311 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5312 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5313 | PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE | B5 | N59 |
| 5314 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5315 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5316 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5317 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5318 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5319 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5320 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5321 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5322 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5323 | PULP THERAPY COMBINATION NOT ALLOWED | B5 | N59 |
| 5324 | WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M | B15 | N59 |
| 5325 | WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M | B15 | N59 |
| 5326 | CORE BUILDUP NOT COVERED WITH OTHER RESTORATION | B5 | N39 |
| 5327 | CORE BUILDUP NOT COVERED WITH OTHER RESTORATION | B5 | N39 |
| 5328 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER. | B5 | N39 |
| 5329 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER. | B5 | N39 |
| 5330 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE. | B5 | N20 |
| 5331 | TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE. | B5 | N20 |
| 5332 | THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL | 97 | N20 |
| 5333 | THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL | 97 | N20 |
| 5334 | PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR | 97 | N20 |
| 5335 | PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR | 97 | N20 |
| 5336 | DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN. | 97 | N59 |
| 5338 | ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY. | 119 | N59 |
| 5340 | ORAL EVALUATION < 3 YRS (D0145) CONTRA | 18 | |
| 5350 | NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME. | 107 | N59 |
| 5351 | PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE. | B5 | N59 |
| 5352 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 125 | N384 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5353 | CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED. | 125 | N384 |
| 5354 | TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING | B5 | N20 |
| 5355 | TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING | B5 | N20 |
| 5400 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER | B5 | N20 |
| 5401 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER | B5 | N20 |
| 5402 | SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC | B5 | N20 |
| 5403 | SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC | B5 | N20 |
| 5404 | EPSDT VISIT HAS BEEN PAID FOR THIS RECIPIENT FOR THE SAME DATE OF SERVICE. | 18 | |
| 5410 | MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC | 119 | N59 |
| 5411 | MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC | 119 | N59 |
| 5412 | PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE. | B5 | N20 |
| 5413 | PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE. | B5 | N20 |
| 5414 | EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY | B5 | N20 |
| 5415 | EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY | B5 | N20 |
| 5416 | VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 | |
| 5417 | VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM | 97 | |
| 5430 | AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC | B5 | N20 |
| 5431 | AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC | B5 | N20 |
| 5432 | PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING. | B5 | N20 |
| 5433 | PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING. | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5434 | PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD. | 119 | |
| 5436 | SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION | B5 | N20 |
| 5437 | SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION | B5 | N20 |
| 5438 | COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY. | B5 | N20 |
| 5439 | COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY. | B5 | N20 |
| 5440 | FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION | B5 | N59 |
| 5441 | FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION | B5 | N59 |
| 5451 | HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME | B5 | N59 |
| 5460 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 | N20 |
| 5461 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 | N20 |
| 5462 | THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450). | 97 | N59 |
| 5464 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 | N20 |
| 5465 | PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT. | 97 | N20 |
| 5470 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 | N20 |
| 5471 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 | N20 |
| 5472 | CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 5473 | CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 5474 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5475 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5476 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5477 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5478 | COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS | B5 | N20 |
| 5479 | COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS | B5 | N20 |
| 5480 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5481 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5482 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5483 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5484 | LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT. | B5 | N59 |
| 5486 | CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE | B5 | N59 |
| 5488 | COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC | B5 | N20 |
| 5500 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5501 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5502 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5503 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5504 | POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT | B5 | N20 |
| 5505 | POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT | B5 | N20 |
| 5506 | SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY | 125 | M83 |
| 5507 | SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY | 125 | M83 |
| 5508 | SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A | 59 | N59 |
| 5509 | SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A | 59 | N59 |
| 5510 | PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY | 119 | N59 |
| 5511 | PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY. | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5512 | PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT. | 119 | N20 |
| 5513 | PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT. | B5 | N20 |
| 5514 | THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED | 97 | N20 |
| 5515 | THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED | 97 | N20 |
| 5516 | ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C | 97 | N20 |
| 5517 | ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C | 97 | N20 |
| 5518 | LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL | 97 | N20 |
| 5519 | LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL | 97 | N20 |
| 5520 | REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE | 59 | N59 |
| 5521 | REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE | 59 | N59 |
| 5522 | ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P | 97 | N20 |
| 5523 | ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P | 97 | N20 |
| 5524 | POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE | 97 | N59 |
| 5525 | POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE | 97 | N59 |
| 5600 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 | N20 |
| 5601 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 | N20 |
| 5602 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5603 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5604 | PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE. | 97 | N19 |
| 5605 | PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE. | 97 | N19 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5606 | PAYMENT MADE FOR SIMILAR PROCEDURE | 97 | N20 |
| 5607 | PAYMENT MADE FOR SIMILAR PROCEDURE | 97 | N20 |
| 5608 | SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP | 97 | M86 |
| 5609 | SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP | 97 | M86 |
| 5610 | PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC | B5 | N20 |
| 5611 | PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT. | B5 | N20 |
| 5612 | PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES | B5 | N20 |
| 5613 | PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES | B5 | N20 |
| 5614 | PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947 | B5 | N20 |
| 5615 | PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947 | B5 | N20 |
| 5616 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 | N20 |
| 5617 | PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE | B5 | N20 |
| 5618 | THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM | B5 | N20 |
| 5619 | THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM | B5 | N20 |
| 5620 | STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER. | B5 | N20 |
| 5621 | STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER. | B5 | N20 |
| 5622 | ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT | B5 | N20 |
| 5623 | ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT | B5 | N20 |
| 5624 | EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY | B14 | N20 |
| 5625 | EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY | B14 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5626 | PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 5627 | PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 5628 | THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT | B13 | M86 |
| 5629 | THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT | B13 | M86 |
| 5630 | INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY. | 97 | N20 |
| 5631 | INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY. | 97 | N20 |
| 5632 | EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER | 97 | N20 |
| 5633 | INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY | 97 | N20 |
| 5634 | THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME | B14 | N20 |
| 5635 | THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME | B14 | N20 |
| 5636 | HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P | 97 | N20 |
| 5637 | HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P | 97 | N20 |
| 5638 | HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL | 97 | N20 |
| 5639 | HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL | 97 | N20 |
| 5640 | SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE | B14 | N20 |
| 5641 | SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE | B14 | N20 |
| 5642 | ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL | 97 | N59 |
| 5643 | ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL | 97 | N59 |
| 5644 | HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY | B14 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5645 | HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY | B14 | N20 |
| 5646 | POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH | 97 | N59 |
| 5647 | POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH | 97 | N59 |
| 5648 | PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134) | B5 | N20 |
| 5650 | ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY | B14 | N20 |
| 5652 | ONLY ONE INITIAL NICU PROCEDURE MAY BE BILLED PER HOSPITAL STAY. | 119 | |
| 5654 | PROCEDURE CODE IS LIMITED TO ONE IN A SERIES | 119 | |
| 5655 | MULTIPLE SURGERY CONTRAS | 18 | |
| 5656 | THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY | 97 | N20 |
| 5658 | A CARDIOLOGIST OR A RADIOLOGIST CANNOT BILL THIS PROCEDURE CODE ON THE SAME DAY | 18 | |
| 5660 | ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY | B14 | N59 |
| 5661 | SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITIAL CARE. | B5 | N390 |
| 5710 | SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5711 | SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5712 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5713 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5714 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5715 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5716 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 | N20 |
| 5717 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 | N20 |
| 5718 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 | N20 |
| 5719 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5720 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5721 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5722 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 | N20 |
| 5723 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT. | B5 | N20 |
| 5724 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5725 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5726 | THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT | B5 | N20 |
| 5727 | THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT | B5 | N20 |
| 5728 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5729 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER. | B5 | N20 |
| 5730 | THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES | 96 | N20 |
| 5731 | THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES | 96 | N20 |
| 5732 | THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY | B5 | N20 |
| 5733 | THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY | B5 | N20 |
| 5734 | THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY | B5 | N20 |
| 5735 | THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY | B5 | N20 |
| 5736 | SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER | B5 | N20 |
| 5738 | SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT | B5 | N20 |
| 5740 | INDIVIDUAL THERAPY AND GROUP THERAPY MAY NOT BE BILLED ON THE SAME DAY. | B14 | N20 |
| 5750 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY | B5 | N20 |
| 5751 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY | B5 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5752 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY | B5 | N20 |
| 5753 | PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY | B5 | N20 |
| 5754 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE | 18 | M86 |
| 5755 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE | 18 | M86 |
| 5760 | ESWL PRICING | 45 | N59 |
| 5770 | INDEPENDENT RURAL HEALTH CLINICS CANNOT BE PAID FOR MORE THAN ONE SERVICE PER D | 119 | |
| 5790 | PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA | 119 | N20 |
| 5791 | PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY | B5 | N20 |
| 5792 | PHYSICAL THERAPY APPLIANCES CONTRA | 119 | N20 |
| 5800 | RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR | 18 | N20 |
| 5801 | RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR | 18 | N20 |
| 5802 | PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D | B5 | N20 |
| 5803 | PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D | B5 | N20 |
| 5804 | ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE. | 18 | N20 |
| 5812 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO | B5 | |
| 5813 | POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLO | B5 | |
| 5814 | PROCEDURE NOT COVERED WITH SPECIFIC CODES. | 97 | N390 |
| 5815 | VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI | 97 | N390 |
| 5816 | HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES. | B5 | N390 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 5817 | REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER. | B5 | N362 |
| 5818 | THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT. | B5 | N390 |
| 5819 | OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE. | B5 | N390 |
| 5830 | PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO | B5 | N59 |
| 5831 | MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD | B5 | N59 |
| 5832 | MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD | B5 | N59 |
| 5910 | NCCI-THIS PROCEDURE SHOULD NOT BE BILLED IN CONJUNCTION WITH ANOTHER PROCEDURE ON THIS CLAIM. | 57 | |
| 5911 | NCCI - THIS PROCEDURE SHOULD NOT BE BILLED IN CONJUNCTION WITH A PROCEDURE ON ANOTHER CLAIM. | 57 | |
| 5912 | THIS PROCEDURE SHOULD NOT BE BILLED IN CONJUNCTION WITH A PROCEDURE ON ANOTHER CLAIM. | 57 | |
| 5930 | NCCI- SVC IS A DUPE OF A SVC PREVIOUSLY BILLED. | 57 | |
| 6001 | THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON | 119 | N59 |
| 6010 | INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR | 119 | N59 |
| 6020 | HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS. | 119 | N59 |
| 6021 | MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS. | 119 | N59 |
| 6022 | MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS. | 119 | N59 |
| 6023 | HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS | 119 | N59 |
| 6024 | THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS. | 119 | N59 |
| 6025 | EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS. | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 6026 | BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS. | 119 | N59 |
| 6030 | NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT | 119 | N59 |
| 6041 | THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 | N59 |
| 6042 | PROCEDURE LIMITED TO ONCE EVERY 30 DAYS. | 119 | N59 |
| 6043 | THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 | N59 |
| 6044 | EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR. | 119 | N59 |
| 6045 | DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME. | 119 | N117 |
| 6046 | PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS | 119 | N59 |
| 6047 | PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS | 119 | N59 |
| 6048 | FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS | 119 | N59 |
| 6049 | PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH. | 119 | N59 |
| 6050 | PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS | 119 | N59 |
| 6051 | FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS | 119 | N59 |
| 6052 | CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION | 15 | M62 |
| 6053 | COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER. | 119 | N117 |
| 6054 | ORAL EVALUATION < 3 YRS (D0145) | 18 | |
| 6056 | FLOURIDE VARNISH < 3YRS - LIMIT 3 PER CAL YEAR | 18 | |
| 6057 | FLOURIDE VARNISH < 3YRS - LIMIT 6 TOTAL | 18 | |
| 6058 | FLOURIDE VARNISH > 3YRS - LIMIT 1 PER CAL YEAR | 18 | |
| 6100 | PROCEDURE IS LIMITED TO SIXTY (60) PER CALENDAR MONTH. | 119 | N59 |
| 6101 | PROCEDURE IS LIMITED TO TWENTY (20) PER CALENDAR MONTH. | 119 | N59 |
| 6102 | PROCEDURE IS LIMITED TO ONE (1) EVERY FIVE YEARS | 119 | N59 |
| 6103 | PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH. | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 6104 | PROCEDURE CODE IS LIMITED TO ONE-HUNDRED (100) PER MONTH. | 119 | N59 |
| 6105 | PROCEDURE IS LIMITED TO 60 (SIXTY) TIMES PER CALENDAR MONTH | 119 | N59 |
| 6106 | PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH | 119 | N59 |
| 6107 | PROCEDURE CODE IS LIMITED TO 40 (FORTY) PER CALENDAR MONTH | 119 | N59 |
| 6108 | PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS | 119 | N59 |
| 6109 | PROCEDURE CODE IS LIMITED TO 100 PER MONTH | 119 | N59 |
| 6110 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 | N59 |
| 6111 | THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE. | 119 | N59 |
| 6112 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE. | 119 | N59 |
| 6113 | PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH | 119 | N59 |
| 6114 | PROCEDURE IS LIMITED TO TWO PER YEAR. | 119 | N59 |
| 6115 | MEDICAL SUPPLIES LIMIT IS \$1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA | 119 | N59 |
| 6116 | PROCEDURE IS LIMITED TO ONE (1) EVERY FOUR CALENDAR YEARS. | 119 | N59 |
| 6117 | THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 | N59 |
| 6118 | THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE | 119 | N59 |
| 6119 | PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS | 119 | N59 |
| 6120 | THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH. | 119 | N59 |
| 6121 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6122 | LEG BAGS ARE LIMITED TO TWO PER MONTH | 119 | N59 |
| 6123 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6124 | PROCEDURE IS LIMITED TO ONE (1) EVERY THREE YEARS. | 119 | N59 |
| 6125 | CATHETERS, CATHETER TRAYS, AND DRAINAGE BAGS ARE LIMITED TO TWO PER MONTH. | 119 | N59 |
| 6126 | PROCEDURE IS LIMITED TO ONE HUNDRED TWENTY (120) PER CALENDAR MONTH. | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 6150 | VISION AND HEARING SCREENING ONE PER YEAR | 119 | N59 |
| 6151 | INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME | 119 | N59 |
| 6152 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6153 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6154 | MAXIMUM UNIT LIMIT HAS BEEN EXCEEDED. | 119 | N59 |
| 6155 | EPSDT SCREENING LIMIT HAS BEEN EXCEEDED. | 119 | N59 |
| 6180 | THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED | 119 | N59 |
| 6181 | THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED | 119 | N59 |
| 6182 | THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED | 119 | N59 |
| 6183 | THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED. | 119 | N59 |
| 6184 | THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED | 119 | N59 |
| 6200 | THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR. | 119 | N59 |
| 6201 | FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR. | 119 | N59 |
| 6202 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6203 | THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD. | 119 | N59 |
| 6204 | INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME | 119 | N59 |
| 6205 | THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR | 119 | N59 |
| 6206 | PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977 | 119 | N59 |
| 6207 | THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O | B5 | N59 |
| 6208 | PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS. | 119 | N59 |
| 6209 | PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD. | 119 | N59 |
| 6230 | MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE SAME DATE OF SERV | B14 | N20 |
| 6231 | MORE THAN ONE DENTAL ENCOUNTER (D9430) CANNOT BE PAID ON THE SAME DATE OF SERVIC | B14 | N20 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 6240 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6241 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6242 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6243 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6244 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6245 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6246 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6247 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6248 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6249 | HBO LIMIT HAS BEEN EXCEEDED | 119 | N59 |
| 6260 | NUMBER OF HOME HEALTH VISITS EXCEED LIMIT | 119 | N59 |
| 6280 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR | 119 | N59 |
| 6281 | OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR. | 119 | N59 |
| 6282 | INPATIENT DAYS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR. | 119 | N59 |
| 6283 | REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER. | B5 | N59 |
| 6290 | MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY | B5 | N20 |
| 6291 | SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY | 119 | N59 |
| 6300 | THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS. | 119 | N59 |
| 6301 | MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS | 119 | N59 |
| 6302 | MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS. | B5 | N59 |
| 6303 | MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS. | B5 | N59 |
| 6310 | THE QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED FOR THE DRUG CODE P | 16 | |
| 6311 | QTY DISPENSED EXCEEDS MAX QTY BASED ON PA | 16 | M123 |
| 6312 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 | |
| 6313 | MONTHLY SCRIPT LIMIT EXCEEDED - BRANDED DRUG | 119 | |
| 6314 | MONTHLY SCRIPT LIMIT EXCEEDED | 119 | |
| 6400 | SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY | 119 | N20 |
| 6401 | OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUI | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 6402 | SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR | 119 | N59 |
| 6403 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR. | 119 | N59 |
| 6404 | PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER | 119 | N59 |
| 6405 | PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS | 119 | N59 |
| 6406 | NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE | 119 | N59 |
| 6407 | THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIP | 119 | N59 |
| 6408 | PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT | B14 | N59 |
| 6409 | REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16 | 119 | N59 |
| 6410 | PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED | 119 | N59 |
| 6411 | INITIAL CRITICAL CARE LIMITED TO ONE PER DAY | 119 | N59 |
| 6412 | ER AND CRITICAL CARE CODE ONE PER CLAIM. | B5 | N20 |
| 6413 | REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16 | 119 | N59 |
| 6510 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6511 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6512 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6513 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6514 | THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR. | 119 | N59 |
| 6515 | THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR | 119 | N59 |
| 6516 | THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR | 119 | N59 |
| 6517 | THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR | 119 | N59 |
| 6518 | PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR. | 119 | N59 |
| 6519 | PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR | 119 | N59 |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 6520 | PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR. | 119 | N59 |
| 6521 | THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR. | 119 | N59 |
| 6522 | THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR. | 119 | N59 |
| 6523 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR YEAR. | 119 | N59 |
| 6524 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 | N59 |
| 6525 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 | N59 |
| 6526 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 | N59 |
| 6527 | BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR YEAR. | 119 | N59 |
| 6528 | BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR. | 119 | N59 |
| 6529 | PROCEDURE IS LIMITED TO 260 UNITS A YEAR. | 119 | N59 |
| 6530 | PROCEDURE IS LIMITED TO 8 UNITS A YEAR. | 119 | N59 |
| 6531 | PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR. | 119 | N59 |
| 6532 | PROCEDURE IS LIMITED TO 1040 UNITS A YEAR. | 119 | N59 |
| 6533 | PROCEDURE IS LIMITED TO 1040 UNITS A YEAR | 119 | N59 |
| 6534 | PROCEDURE IS LIMITED TO 2016 UNITS A YEAR. | 119 | N59 |
| 6535 | PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR. | 119 | N59 |
| 6536 | PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR. | 119 | N59 |
| 6537 | PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR. | 119 | N59 |
| 6538 | YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED | 119 | N59 |
| 6539 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6540 | PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF | 119 | N59 |
| 6541 | DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR | 119 | N59 |
| 6542 | PROCEDURE IS LIMITED TO 4160 UNITS A YEAR. | 119 | N59 |
| 6600 | RADIOLOGY - PROCEDURE REQUIRES PRIOR AUTHORIZATION | 197 | |
| 6610 | DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER | 119 | N59 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 6611 | PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR. | 119 | N59 |
| 6612 | PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH. | 119 | N59 |
| 6613 | PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME. | 119 | N59 |
| 6630 | THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH. | 119 | N59 |
| 6640 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6641 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6642 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6643 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6644 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6645 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6646 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. | 119 | N59 |
| 6647 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6650 | THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THIS CONTRACT YEAR | 119 | N59 |
| 6651 | UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED | 119 | N59 |
| 6652 | UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED | 119 | N59 |
| 6653 | PROCEDURE LIMITED TO 1080 HOURS,PER WAIVER YEAR OCTOBER 1 - SEPTEMBER 30. | 119 | N59 |
| 6670 | THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED | 119 | N59 |
| 6671 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS RECIP | 18 | |
| 6672 | OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE | 18 | |
| 6673 | PROCEDURE IS LIMITED TO ONE (1) EVERY TWO YEARS. | 119 | N59 |
| 6674 | CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL. | 18 | |
| 6677 | PROCEDURE CODE CANNOT BE BILLED MORE THAN SIX(6) TIMES WITH THE SAME MODIFIER. | 18 | M86 |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 6690 | REVENUE CODE 183 IS LIMITED TO 6 DAYS EACH CALENDAR QUARTER. | 119 | N43 |
| 6691 | REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDAR MONTH | 119 | N43 |
| 7000 | CLAIM FAILED A PRODUR ALERT | 133 | |
| 7001 | INFORMATIONAL PRODUR ALERT | 175 | |
| 7002 | CLAIM DENIED FOR PRODUR REASONS | 6 | |
| 7003 | PRODUR ALERT REQUIRES PA FOR OVERRIDE | 6 | |
| 7004 | NON-OVERRIDEABLE PRODUR ALERT | 6 | |
| 7200 | MISCELLANEOUS CLAIMCHECK ERROR | 6 | |
| 7201 | PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR | 6 | |
| 7202 | PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS | 6 | |
| 7203 | PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS | 6 | |
| 7204 | PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS | 6 | |
| 7205 | PROCEDURE IS NOT INDICATED FOR A MALE | 7 | |
| 7206 | PROCEDURE IS NOT INDICATED FOR A FEMALE | 7 | |
| 7207 | PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE | 96 | |
| 7208 | PROCEDURE IS AN UNLISTED PROCEDURE | 96 | |
| 7209 | PROCEDURE IS CLASSIFIED AS EXPERIMENTAL | 96 | |
| 7210 | PROCEDURE IS CLASSIFIED AS OBSOLETE | 96 | |
| 7211 | PROCEDURE IS INVALID FOR PATIENT'S AGE | 6 | |
| 7213 | PROCEDURE IS INVALID FOR PATIENT'S SEX | 7 | N22 |
| 7214 | PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX) | 7 | MA39 |
| 7215 | PROCEDURE CODE IS INCIDENTAL | 125 | N22 |
| 7216 | VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT | 96 | N19 |
| 7217 | PROCEDURE CODE HAS BEEN REBUNDLED | 125 | |
| 7218 | PROCEDURE ADDED DUE TO REBUNDLING | 125 | |
| 7219 | PROCEDURE IS MUTUALLY EXCLUSIVE | 125 | N22 |
| 7220 | PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE | B13 | |
| 7221 | PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE | B13 | M144 |
| 7222 | PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON | 4 | M144 |
| 7223 | PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON | 4 | |
| 7233 | DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL | 18 | |

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|---|------------------------------|-------------------|
| 7234 | DENIED DUPLICATE - IS BILATERAL | 18 | |
| 7235 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME | 18 | |
| 7236 | DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY | 18 | |
| 7237 | DENIED DUPLICATE (REBUNDLED) | 18 | |
| 7238 | PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING | 125 | |
| 7239 | PROCEDURE IS A POSSIBLE DUPLICATE | 18 | N22 |
| 7240 | SMARTSUSPENSE SUSPEND | 45 | |
| 7241 | SMARTSUSPENSE DENIAL | 16 | |
| 7242 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED | 11 | |
| 7243 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED | 11 | |
| 7244 | MEDICAL VISIT DENIED | 16 | |
| 7245 | PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT | 16 | |
| 7246 | PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT | 16 | N22 |
| 7247 | PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT | 16 | N22 |
| 7248 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS | 11 | N22 |
| 7249 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT | 18 | |
| 7250 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT | 18 | |
| 7251 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR | B20 | |
| 7252 | DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC | B20 | |
| 7253 | DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC | B20 | |
| 7254 | DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC | B20 | |
| 7255 | DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR THIRD PARTY PAYOR BY CLAIMC | B20 | |
| 7256 | MODIFIER 51 INVALID FOR PRIMARY PROCEDURE | 4 | |
| 7257 | MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE | 4 | |
| 7258 | REVIEW MODIFIER 51 | 4 | |
| 7259 | SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS | 35 | |

Provider Remittance Advice (RA) Codes

| EOB CODE | EOB DESCRIPTION | HIPAA ADJUSTMENT REASON CODE | HIPAA REMARK CODE |
|----------|--|------------------------------|-------------------|
| 7260 | MORE THAN 40 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING | 35 | |
| 7261 | INVALID PROCEDURE CODE | 96 | |
| 7262 | DOB CANNOT BE GREATER THAN DATE OF SERVICE | 14 | N56 |
| 7263 | DOS REQUIRED FOR PROCEDURE | 16 | |
| 7268 | PROVIDER IS REQUIRED FOR HISTORY PROCEDURES | 125 | |
| 7270 | INVALID MODIFIER/PROCEDURE CODE COMBINATION | 4 | M78 |
| 7271 | CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID | 125 | M78 |
| 7277 | PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE | 11 | |
| 7278 | INVALID DATE (DATE OF BIRTH) | 16 | |
| 7279 | INVALID AMOUNT CHARGED | 125 | M38 |
| 7280 | CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED | 125 | MA54 |
| 7281 | DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE | 11 | |
| 7282 | INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS | 11 | |
| 7283 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT | 45 | |
| 7284 | PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT | 133 | |
| 7285 | PROCEDURE IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR | B20 | |
| 7286 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR | B20 | |
| 7287 | DIAGNOSIS IS ELIGIBLE FOR WORKER'S COMPENSATION/AUTO PAYOR | 92 | |
| 7288 | SMARTSUSPENSE FLAG | 133 | M100 |
| 7289 | SMARTSUSPENSE MONITOR | 133 | |
| 7290 | MODIFIER 51 DELETED FOR PRIMARY PROCEDURE | 4 | |
| 7291 | MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE | 4 | |
| 7500 | REVIEW CLAIM FOR PAY-TO- PROVIDER | 16 | |
| 7503 | CONFLICT CODE ON RESPONSE CLAIM DOES NOT MATCH | 16 | |
| 7509 | REVIEW CLAIMS FOR THIS PROVIDER | 133 | |
| 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY | 45 | |
| 9999 | PROCESSED PER MEDICAID POLICY | 45 | |