



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

Appendix J as of 12/06/2013

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
201	INVALID PAY-TO PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	201	INVALID PAY-TO PROVIDER NUMBER
203	RECIPIENT I.D. NUMBER MISSING	31	Claim denied as patient cannot be identified as our insured.	203	RECIPIENT I.D. NUMBER MISSING
204	RECIPIENT ID - OLD FORMAT	A1	Claim/Service denied.	204	RECIPIENT ID - OLD FORMAT
206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT
212	MISSING PRESCRIPTION NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	212	MISSING PRESCRIPTION NUMBER
215	DATE DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	215	DATE DISPENSED IS MISSING
216	DATE DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	216	DATE DISPENSED IS INVALID
217	MISSING DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	217	MISSING DRUG CODE

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
218	INVALID DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	218	INVALID DRUG CODE
219	QUANTITY DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	219	QUANTITY DISPENSED IS MISSING
220	QUANTITY DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	220	QUANTITY DISPENSED IS INVALID
223	MISSING DIAGNOSIS INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	223	MISSING DIAGNOSIS INDICATOR
224	DIAGNOSIS TREATMENT INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	224	DIAGNOSIS TREATMENT INDICATOR INVALID
225	REFERRING PROVIDER - INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	225	REFERRING PROVIDER - INVALID FORMAT
226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER
233	UNITS OF SERVICE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	233	UNITS OF SERVICE MISSING
234	PROCEDURE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	234	PROCEDURE CODE MISSING
235	PROCEDURE CODE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed	235	PROCEDURE CODE NOT IN VALID FORMAT

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
236	NO PROCEDURE FOR REVENUE CODE; MEDICAID HAS NO PAYMENT LIABILITY FOR THIS LINE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	236	NO PROCEDURE FOR REVENUE CODE; MEDICAID HAS NO PAYMENT LIABILITY FOR THIS LINE
239	DETAIL TO DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	239	DETAIL TO DATE OF SERVICE IS MISSING
240	THE DETAIL "TO" DATE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	240	THE DETAIL "TO" DATE IS INVALID
243	MISSING MEDICARE PAID DATE	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	243	MISSING MEDICARE PAID DATE
248	PLACE OF SERVICE IS MISSING OR BLANK	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	248	PLACE OF SERVICE IS MISSING OR BLANK
249	PLACE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	249	PLACE OF SERVICE IS INVALID
250	CLAIM HAS NO DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	250	CLAIM HAS NO DETAILS
255	PATIENT RSN FOR VISIT REQ ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	255	PATIENT RSN FOR VISIT REQ ON OUTPATIENT HOSP CLAIM
256	ADMIT DIAGNOSIS INVALID ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	256	ADMIT DIAGNOSIS INVALID ON OUTPATIENT HOSP CLAIM
257	PATIENT RSN FOR VISIT INVALID ON INPATIENT CLAIM	97	The benefit for this service is included in the	257	PATIENT RSN FOR VISIT INVALID ON INPATIENT CLAIM

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			payment/allowance for another service/procedure that has already been adjudicated.		
258	MISSING DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	258	MISSING DIAGNOSIS CODE
260	UNITS OF SERVICE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	260	UNITS OF SERVICE NOT IN VALID FORMAT
261	MISSING TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	261	MISSING TOOTH NUMBER
262	INVALID TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	262	INVALID TOOTH NUMBER
263	INVALID TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	263	INVALID TOOTH SURFACE
264	DETAIL FROM DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	264	DETAIL FROM DATE OF SERVICE IS MISSING
265	DETAIL FROM DATE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	265	DETAIL FROM DATE OF SERVICE IS INVALID
266	MISSING TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	266	MISSING TOOTH SURFACE
268	BILLED AMOUNT INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	268	BILLED AMOUNT INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT
270	MISSING TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	270	MISSING TOTAL CLAIM CHARGE
271	INVALID TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	271	INVALID TOTAL CLAIM CHARGE
273	TYPE OF BILL MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	273	TYPE OF BILL MISSING
274	TYPE OF BILL CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	274	TYPE OF BILL CODE INVALID
275	ADMIT DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	275	ADMIT DATE MISSING
276	ADMIT DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	276	ADMIT DATE INVALID
277	INVALID ADMISSION HOUR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	277	INVALID ADMISSION HOUR
278	ADMIT TYPE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	278	ADMIT TYPE MISSING

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
279	INVALID TYPE OF ADMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	279	INVALID TYPE OF ADMISSION
280	PATIENT STATUS IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	280	PATIENT STATUS IS MISSING
281	PATIENT STATUS IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	281	PATIENT STATUS IS INVALID
282	MISSING COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	282	MISSING COVERED DAYS
283	COVERED DAYS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	283	COVERED DAYS INVALID
284	PRIMARY CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	284	PRIMARY CONDITION CODE INVALID
285	SECOND CONDITON CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	285	SECOND CONDITON CODE INVALID
286	THIRD CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	286	THIRD CONDITION CODE INVALID
287	FOURTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	287	FOURTH CONDITION CODE INVALID
288	FIFTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed	288	FIFTH CONDITION CODE INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
289	SIXTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	289	SIXTH CONDITION CODE INVALID
290	SEVENTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	290	SEVENTH CONDITION CODE INVALID
295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	295	DATE FOR PRIMARY OCCURRENCE CODE MISSING
296	DATE FOR PRIMARY OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	296	DATE FOR PRIMARY OCCURRENCE CODE INVALID
297	DATE FOR SECOND OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	297	DATE FOR SECOND OCCURRENCE CODE MISSING
298	DATE FOR SECOND OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	298	DATE FOR SECOND OCCURRENCE CODE INVALID
299	DATE FOR THIRD OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	299	DATE FOR THIRD OCCURRENCE CODE MISSING
300	DATE FOR THIRD OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	300	DATE FOR THIRD OCCURRENCE CODE INVALID
301	DATE FOR FOURTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied	301	DATE FOR FOURTH OCCURRENCE CODE MISSING

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			using remittance advice remarks codes whenever appropriate		
302	DATE FOR FOURTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	302	DATE FOR FOURTH OCCURRENCE CODE INVALID
306	BOTH ICD-9 AND ICD-10 CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	306	BOTH ICD-9 AND ICD-10 CODES NOT ALLOWED
307	BOTH ICD-9 AND ICD-10 PROC CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	307	BOTH ICD-9 AND ICD-10 PROC CODES NOT ALLOWED
308	BOTH ICD-9 AND ICD-10 DIAG CODES NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	308	BOTH ICD-9 AND ICD-10 DIAG CODES NOT ALLOWED
309	ICD PROCEDURE VERSION INVALID FOR COMPLIANCE DATES	181	"PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE	309	ICD PROCEDURE VERSION INVALID FOR COMPLIANCE DATES
"				"	
310	ICD DIAGNOSIS VERSION INVALID FOR COMPLIANCE DATES	146	Diagnosis was invalid for the date(s) of service reported.	310	ICD DIAGNOSIS VERSION INVALID FOR COMPLIANCE DATES
339	REVENUE CODE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	339	REVENUE CODE IS MISSING
340	REVENUE CODE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	340	REVENUE CODE IS INVALID
350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.
364	PRINCIPAL ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	364	PRINCIPAL ICD PROCEDURE DATE MISSING
365	PRINCIPAL ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	365	PRINCIPAL ICD PROCEDURE DATE INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
367	FIRST OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	367	FIRST OTHER ICD PROCEDURE DATE MISSING
368	FIRST OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	368	FIRST OTHER ICD PROCEDURE DATE INVALID
369	SECOND OTHER PROCEDURE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	369	SECOND OTHER PROCEDURE CODE INVALID
370	SECOND OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	370	SECOND OTHER ICD PROCEDURE DATE MISSING
371	SECOND OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	371	SECOND OTHER ICD PROCEDURE DATE INVALID
373	THIRD OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	373	THIRD OTHER ICD PROCEDURE DATE MISSING
374	THIRD OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	374	THIRD OTHER ICD PROCEDURE DATE INVALID
376	FOURTH OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	376	FOURTH OTHER ICD PROCEDURE DATE MISSING
377	FOURTH OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	377	FOURTH OTHER ICD PROCEDURE DATE INVALID

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
379	FIFTH OTHER ICD PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	379	FIFTH OTHER ICD PROCEDURE DATE MISSING
380	FIFTH OTHER ICD PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	380	FIFTH OTHER ICD PROCEDURE DATE INVALID
381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING
395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING
396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID
397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING
398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO
411	DATE FOR FIFTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	411	DATE FOR FIFTH OCCURRENCE CODE MISSING
412	DATE FOR FIFTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed	412	DATE FOR FIFTH OCCURRENCE CODE INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
413	DATE FOR SIXTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	413	DATE FOR SIXTH OCCURRENCE CODE MISSING
414	DATE FOR SIXTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	414	DATE FOR SIXTH OCCURRENCE CODE INVALID
415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	415	DATE FOR SEVENTH OCCURRENCE CODE MISSING
416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	416	DATE FOR SEVENTH OCCURRENCE CODE INVALID
417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	417	DATE FOR EIGHTH OCCURRENCE CODE MISSING
418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	418	DATE FOR EIGHTH OCCURRENCE CODE INVALID
433	MEDICARE DEDUCTIBLE AMOUNT INVALID	1	DEDUCTIBLE AMOUNT	433	MEDICARE DEDUCTIBLE AMOUNT INVALID
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	436	TOTAL MEDICARE ALLOWED AMOUNT INVALID
450	INVALID QUADRANT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	450	INVALID QUADRANT
455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	125	Payment adjusted due to a submission/billing error(s).	455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			Additional information is supplied using the remittance advice remarks codes whenever appropriate.		
456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER
457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE
465	DATE FOR OCCURRENCE CODE 9-24 MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	465	DATE FOR OCCURRENCE CODE 9-24 MISSING
466	DATE FOR OCCURRENCE CODE 9-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	466	DATE FOR OCCURRENCE CODE 9-24 INVALID
471	CONDITION CODE 8-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	471	CONDITION CODE 8-24 INVALID
473	ICD PROCEDURE 7-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	473	ICD PROCEDURE 7-24 INVALID
474	ICD PROCEDURE 7-24 OR DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	474	ICD PROCEDURE 7-24 OR DATE MISSING
475	ICD PROCEDURE 7-24 DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	475	ICD PROCEDURE 7-24 DATE INVALID
500	DATE PRESCRIBED AFTER BILLING DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the	500	DATE PRESCRIBED AFTER BILLING DATE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate.		
502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
503	DATE DISPENSED AFTER BILLING DATE	110	BILLING DATE PREDATES SERVICE DATE.	503	DATE DISPENSED AFTER BILLING DATE
507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS
512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT
513	NAME ON CLAIM MUST MATCH NAME ON FILE	140	Patient/Insured health identification number and name do not match.	513	NAME ON CLAIM MUST MATCH NAME ON FILE
514	DATE RECEIVED FOR PROCESSING- PRIOR TO DATE OF SERV	110	BILLING DATE PREDATES SERVICE DATE.	514	DATE RECEIVED FOR PROCESSING- PRIOR TO DATE OF SERV
519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE	110	BILLING DATE PREDATES SERVICE DATE.	519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE
526	DETAIL DATES NOT WITHIN HEADER DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	526	DETAIL DATES NOT WITHIN HEADER DATES
527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE
537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE
555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT
557	MEPD LATE FILING	29	The time limit for filing has expired.	557	MEPD LATE FILING
570	TOTAL DAYS LESS THAN COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	570	TOTAL DAYS LESS THAN COVERED DAYS

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
571	SURGICAL PROCEDURE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	571	SURGICAL PROCEDURE MISSING
573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
574	SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	574	SERVICE DATES ARE NOT IN SAME MONTH
575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE
577	DETAIL SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	577	DETAIL SERVICE DATES ARE NOT IN SAME MONTH
589	ADJUSTMENT HAS AUTO DENIAL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	589	ADJUSTMENT HAS AUTO DENIAL
595	MANUALLY SUSPEND FOR REVIEW	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	595	MANUALLY SUSPEND FOR REVIEW
596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	129	Payment denied - Prior processing information appears incorrect.	596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
602	UNITS NOT EQUAL TO TEETH BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	602	UNITS NOT EQUAL TO TEETH BILLED
606	INVALID OTHER PAYER DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	606	INVALID OTHER PAYER DATE
620	TPL DEDUCTIBLE AMOUNT NOT	16	Claim/service lacks	620	TPL DEDUCTIBLE AMOUNT NOT

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	NUMERIC		information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		NUMERIC
621	TPL COINSURANCE AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	621	TPL COINSURANCE AMOUNT NOT NUMERIC
622	TPL COPAY AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	622	TPL COPAY AMOUNT NOT NUMERIC
623	TPL PAID AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	623	TPL PAID AMOUNT NOT NUMERIC
624	TPL DETAIL PAYER DOES NOT HAVE MATCHING HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	624	TPL DETAIL PAYER DOES NOT HAVE MATCHING HDR PAYER
625	TPL DETAIL PAYER HAS MULTIPLE MATCHING HDR PAYERS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	625	TPL DETAIL PAYER HAS MULTIPLE MATCHING HDR PAYERS
626	TPL DETAIL PAYER ID HAS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	626	TPL DETAIL PAYER ID HAS DUPLICATE
627	TPL HDR COINSURANCE <> SUM OF DTL COINSURANCE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	627	TPL HDR COINSURANCE <> SUM OF DTL COINSURANCE
628	TPL HDR DEDUCTIBLE NOT EQUAL SUM OF DTL DEDUCTIBLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	628	TPL HDR DEDUCTIBLE NOT EQUAL SUM OF DTL DEDUCTIBLE
629	TPL HDR COPAY NOT EQUAL SUM OF DTL COPAY	16	Claim/service lacks information which is needed for adjudication. Additional	629	TPL HDR COPAY NOT EQUAL SUM OF DTL COPAY

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
630	TPL HDR PAID AMT NOT EQUAL SUM OF DTL PAID AMT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	630	TPL HDR PAID AMT NOT EQUAL SUM OF DTL PAID AMT
631	TPL - PATIENT RESPONSIBILITY IS ZERO FOR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	631	TPL - PATIENT RESPONSIBILITY IS ZERO FOR PAYER
632	TPL HDR PAYER HAS NO DETAIL PAYER INFORMATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	632	TPL HDR PAYER HAS NO DETAIL PAYER INFORMATION
633	TPL HDR PAYER ID IS DUPLICATE OF ANOTHER HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	633	TPL HDR PAYER ID IS DUPLICATE OF ANOTHER HDR PAYER
634	TPL PAYER RESPONSIBILITY MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	634	TPL PAYER RESPONSIBILITY MISSING OR INVALID
635	TPL PAYER RESPONSIBILITY HIERARCHY IS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	635	TPL PAYER RESPONSIBILITY HIERARCHY IS DUPLICATE
636	TPL TOTAL PAID AMT NOT EQUAL SUM OF HDR PAID AMT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	636	TPL TOTAL PAID AMT NOT EQUAL SUM OF HDR PAID AMT
637	CLAIM WITH TPL AMOUNT MISSING TPL PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	637	CLAIM WITH TPL AMOUNT MISSING TPL PAYER
643	INVALID OTHER COVERAGE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	643	INVALID OTHER COVERAGE CODE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
644	OTHER PAYER PAT RESP AMT IS INVALID	3	Co-payment Amount	644	OTHER PAYER PAT RESP AMT IS INVALID
645	OTHER PAYER PAT RESP QUALIFIER IS INVALID	3	Co-payment Amount	645	OTHER PAYER PAT RESP QUALIFIER IS INVALID
675	ADJ - RECIPIENT ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	675	ADJ - RECIPIENT ID NOT SUBMITTED
676	ADJ - PROVIDER ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	676	ADJ - PROVIDER ID NOT SUBMITTED
677	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	677	ADJ - ORIGINAL ICN NOT FOUND
678	ADJ - ORIGINAL ICN NOT SUBMITTED	107	The related or qualifying claim/service was not identified on this claim.	678	ADJ - ORIGINAL ICN NOT SUBMITTED
679	ADJ - REQUEST RECIPIENT ID NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	679	ADJ - REQUEST RECIPIENT ID NOT FOUND
680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL
681	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	681	ADJ - ORIGINAL ICN NOT FOUND
684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL
685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS
686	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	686	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE
687	CANNOT ADJUST THIS CLAIM DUE TO	16	Claim/service lacks	687	CANNOT ADJUST THIS CLAIM DUE TO

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT		information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT
800	DETAIL RATE NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	800	DETAIL RATE NOT NUMERIC
801	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	801	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT
803	DATED EXCEED SOBRA/QMB ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	803	DATED EXCEED SOBRA/QMB ELIGIBILITY
805	NONCOVERED CHARGE IS NOT NUMERIC	96	Non-covered charge(s).	805	NONCOVERED CHARGE IS NOT NUMERIC
806	MEDICARE PAID AMOUNT MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	806	MEDICARE PAID AMOUNT MISSING OR INVALID
807	INVALID TPL ADJUDICATION DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	807	INVALID TPL ADJUDICATION DATE
808	TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	808	TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE
809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS
811	HEADER FROM DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	811	HEADER FROM DATE OF SERVICE > ICN DATE
812	ADMIT DATE IS GREATER THAN ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the	812	ADMIT DATE IS GREATER THAN ICN DATE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate.		
813	MEDICARE PAID DATE > ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	813	MEDICARE PAID DATE > ICN DATE
814	DETAIL TO DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	814	DETAIL TO DATE OF SERVICE > ICN DATE
815	SURGICAL ICD REQUIRES OPERATING PHYSICIAN	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	815	SURGICAL ICD REQUIRES OPERATING PHYSICIAN
816	COINSURANCE DAYS NOT NUMERIC	2	Coinsurance Amount	816	COINSURANCE DAYS NOT NUMERIC
817	INVALID COINSURANCE DAYS	2	Coinsurance Amount	817	INVALID COINSURANCE DAYS
818	LIFETIME RESERVE DAYS NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	818	LIFETIME RESERVE DAYS NOT NUMERIC
819	LIFETIME RESERVE DAYS > MAX ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	819	LIFETIME RESERVE DAYS > MAX ALLOWED
820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR
821	NON-COVERED DAYS MISSING OR NOT NUMERIC	78	Non-Covered days/Room charge adjustment.	821	NON-COVERED DAYS MISSING OR NOT NUMERIC
822	SURGICAL REVENUE CODE REQUIRES ICD SURGERY CODE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	822	SURGICAL REVENUE CODE REQUIRES ICD SURGERY CODE
823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID
825	MEDICARE ALLOWED AMOUNT	125	Payment adjusted due to a	825	MEDICARE ALLOWED AMOUNT

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	MISSING OR INVALID		submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		MISSING OR INVALID
826	TYPE OF BILL INVALID FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	826	TYPE OF BILL INVALID FOR CLAIM TYPE
830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW
840	ICD-10 CLAIM SPANS ICD-10 START DATE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	840	ICD-10 CLAIM SPANS ICD-10 START DATE
841	ICD-9 CLAIM SPANS ICD-9 END DATE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	841	ICD-9 CLAIM SPANS ICD-9 END DATE
900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND
901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE
902	PROCEDURE CODE GROUP NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	902	PROCEDURE CODE GROUP NOT FOUND
903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T
905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL
906	GROUP NUMBER NOT FOUND IN ICD GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	906	GROUP NUMBER NOT FOUND IN ICD GROUP TABLE
909	GROUP NUMBER NOT FOUND IN	16	Claim/service lacks	909	GROUP NUMBER NOT FOUND IN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DIAGNOSIS GROUP TABLE		information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		DIAGNOSIS GROUP TABLE
913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE
914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE
915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE
916	GROUP NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	916	GROUP NOT FOUND IN PROVIDER GROUP TABLE
917	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	917	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE
918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR
919	GROUP NUMBER NOT FOUND IN AID CODE TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	919	GROUP NUMBER NOT FOUND IN AID CODE TABLE
921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE
924	SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND	63	Correction to a prior claim.	924	SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND
925	GROUP NUMBER NOT FOUND IN REFERENCE GROUP TABLE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	925	GROUP NUMBER NOT FOUND IN REFERENCE GROUP TABLE.
1000	NO PAY-TO PROVIDER RECORD	16	Claim/service lacks information which is needed for adjudication. Additional	1000	NO PAY-TO PROVIDER RECORD

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE
1002	PERFORMING PROV NOT ELIGIBLE FOR DOS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	1002	PERFORMING PROV NOT ELIGIBLE FOR DOS
1003	PROVIDER INELIGIBLE ON DATE OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	1003	PROVIDER INELIGIBLE ON DATE OF SERVICE
1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE
1010	PERFORMING PROVIDER NOT IN BILLING GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1010	PERFORMING PROVIDER NOT IN BILLING GROUP
1018	CLINIC RATE NOT ON FILE FOR HOSPITAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1018	CLINIC RATE NOT ON FILE FOR HOSPITAL
1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV	38	Services not provided or authorized by designated (network/primary care) providers.	1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV
1032	PROVIDER TYPE - CLAIM INPUT CONFLICT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1032	PROVIDER TYPE - CLAIM INPUT CONFLICT
1038	DEA NOT ON FILE FOR PRESCRIBER	3	Co-payment Amount	1038	DEA NOT ON FILE FOR PRESCRIBER
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED	3	Co-payment Amount	1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE	3	Co-payment Amount	1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE
1041	PRESCRIBER PRACTICE TYPE NOT VALID FOR DRUG SCHED	3	Co-payment Amount	1041	PRESCRIBER PRACTICE TYPE NOT VALID FOR DRUG SCHED
1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)
1054	ORDERING PROVIDER NOT ON FILE	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT	1054	ORDERING PROVIDER NOT ON FILE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.		
"				"	
1065	PROVIDER NAME MISMATCH	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1065	PROVIDER NAME MISMATCH
1079	ORDERING PROV NOT ENROLLED SVC LOCATION	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1079	ORDERING PROV NOT ENROLLED SVC LOCATION
"				"	
1100	ORDERING PROV - STATUS NOT VALID FOR DOS	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1100	ORDERING PROV - STATUS NOT VALID FOR DOS
"				"	
1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER
1804	VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1804	VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER
1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS
1807	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1807	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE
1810	PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	1810	PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS
1815	PERF PROV ENROLL STATUS NOT VALID FOR DOS	16	Claim/service lacks information which is needed	1815	PERF PROV ENROLL STATUS NOT VALID FOR DOS

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS
1819	INVALID POS FOR FQHC PROVIDER	5	The procedure code/bill type is inconsistent with the place of service.	1819	INVALID POS FOR FQHC PROVIDER
1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL	38	Services not provided or authorized by designated (network/primary care) providers.	1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL
1825	COBA DENIAL - DO NOT CROSSOVER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1825	COBA DENIAL - DO NOT CROSSOVER
1826	SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1826	SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE
1827	NON-MEPD CLAIM FOR MEPD RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	1827	NON-MEPD CLAIM FOR MEPD RECIPIENT
1830	PROCEDURE REQUIRES BOTH ORDERING AND REF PROVIDER	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1830	PROCEDURE REQUIRES BOTH ORDERING AND REF PROVIDER
"				"	
1832	PROCEDURE REQUIRES REFERRING PROVIDER	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1832	PROCEDURE REQUIRES REFERRING PROVIDER
"				"	
1833	PROCEDURE REQUIRES ORDERING PROVIDER	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1833	PROCEDURE REQUIRES ORDERING PROVIDER
"				"	
1900	TAXONOMY IS INVALID BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1900	TAXONOMY IS INVALID BILLING PROVIDER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1901	TAXONOMY IS INVALID PREFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1901	TAXONOMY IS INVALID PREFORMING PROVIDER
1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER
1907	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1907	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER
1912	TAXONOMY IS MISSING: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1912	TAXONOMY IS MISSING: BILLING PROVIDER
1913	TAXONOMY IS MISSING: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1913	TAXONOMY IS MISSING: PERFORMING PROVIDER
1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER
1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER
1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV
1927	BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N	206	National Provider Identifier - missing	1927	BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N
1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV	206	National Provider Identifier - missing	1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV
1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV	206	National Provider Identifier - missing	1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	206	National Provider Identifier - missing	1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)
1961	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1961	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)
1962	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1962	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)
1968	NPI REQUIRED: ORDERING PROVIDER (HEALTHCARE)	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1968	NPI REQUIRED: ORDERING PROVIDER (HEALTHCARE)
"				"	
1969	INVALID DTL ORDERING PROVIDER OVERRIDE SPECIFIED	184	"THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	1969	INVALID DTL ORDERING PROVIDER OVERRIDE SPECIFIED
"				"	
1974	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1974	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER
1975	TAXONOMY IS INVALID: DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1975	TAXONOMY IS INVALID: DTL REFERRING PROVIDER
1976	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1976	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2
1977	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1977	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
1978	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1978	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV
1979	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1979	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER
1980	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1980	TAXONOMY IS NOT VALID FOR BILLING PROVIDER
1981	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1981	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER
1982	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1982	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER
1983	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1983	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER
1984	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1984	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2
1985	TAXONOMY IS INVALID: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1985	TAXONOMY IS INVALID: BILLING PROVIDER
1986	TAXONOMY IS INVALID: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1986	TAXONOMY IS INVALID: PERFORMING PROVIDER
1987	TAXONOMY IS INVALID: REFERRING PROVIDER	16	Claim/service lacks information which is needed	1987	TAXONOMY IS INVALID: REFERRING PROVIDER

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
1988	TAXONOMY IS INVALID: FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1988	TAXONOMY IS INVALID: FACILITY PROVIDER
1989	TAXONOMY IS INVALID: OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	1989	TAXONOMY IS INVALID: OTHER PROVIDER 2
2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	96	Non-covered charge(s).	2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY
2053	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	2053	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2057	RECIPIENT PARTIALLY ELIGIBLE - HEADER	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	2057	RECIPIENT PARTIALLY ELIGIBLE - HEADER
2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES
2504	FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	2504	FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER
2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT)
2507	THIS PATIENT HAS TWO COVERAGE TYPES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	2507	THIS PATIENT HAS TWO COVERAGE TYPES
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.
2804	DETAILS COVERED BY MORE THAN	141	Claim adjustment because	2804	DETAILS COVERED BY MORE THAN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	ONE PLAN CODE		the claim spans eligible and ineligible periods of coverage.		ONE PLAN CODE
2807	COBA-NO MEDICAID ID FOR MEDICARE ID	31	Claim denied as patient cannot be identified as our insured.	2807	COBA-NO MEDICAID ID FOR MEDICARE ID
2808	COBA - MEDICARE ID NOT ON FILE	31	Claim denied as patient cannot be identified as our insured.	2808	COBA - MEDICARE ID NOT ON FILE
2850	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2850	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME
2851	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2851	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN
2852	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	2852	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.
3019	PA CUTBACK PERFORMED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	3019	PA CUTBACK PERFORMED
3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH
3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES
3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH
3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID
3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT
3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION	5	The procedure code/bill type is inconsistent with the place of service.	3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION
3313	NDC DRUG, PRODUCT IS NOT PREFERRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3313	NDC DRUG, PRODUCT IS NOT PREFERRED
3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP	16	Claim/service lacks information which is needed	3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
3315	NURSERY DAYS EXCEED LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	3315	NURSERY DAYS EXCEED LIMIT
3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID
3351	PRIMARY DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3351	PRIMARY DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3352	SECOND DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3352	SECOND DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3353	THIRD DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3353	THIRD DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3354	FOURTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3354	FOURTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3355	FIFTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3355	FIFTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3356	SIXTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3356	SIXTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3357	SEVENTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3357	SEVENTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3358	EIGHTH DIAGNOSIS REQUIRES	16	Claim/service lacks	3358	EIGHTH DIAGNOSIS REQUIRES

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	PRESENT ON ADMISSION INDICATOR		information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		PRESENT ON ADMISSION INDICATOR
3359	NINTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3359	NINTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR
3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION
3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION
4001	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION	12	The diagnosis is inconsistent with the provider type.	4001	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION
4002	BPA-RP-NDC - NO COVERAGE	96	Non-covered charge(s).	4002	BPA-RP-NDC - NO COVERAGE
4004	NDC IS NOT ON FILE	96	Non-covered charge(s).	4004	NDC IS NOT ON FILE
4013	PROCEDURE CODE IS NO LONGER VALID	96	Non-covered charge(s).	4013	PROCEDURE CODE IS NO LONGER VALID
4014	NO PRICING SEGMENT IS ON FILE.	133	The disposition of this claim/service is pending further review.	4014	NO PRICING SEGMENT IS ON FILE.
4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	12	The diagnosis is inconsistent with the provider type.	4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION
4021	BPA-RP-PROC - NO COVERAGE	96	Non-covered charge(s).	4021	BPA-RP-PROC - NO COVERAGE
4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION
4032	PROCEDURE CODE IS MISSING/NOT ON FILE	96	Non-covered charge(s).	4032	PROCEDURE CODE IS MISSING/NOT ON FILE
4038	PATIENT REASON FOR VISIT DIAGNOSIS NOT ON FILE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4038	PATIENT REASON FOR VISIT DIAGNOSIS NOT ON FILE
4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	96	Non-covered charge(s).	4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4054	FIRST OTHER PROCEDURE CODE NOT ON FILE

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4055	SECOND OTHER PROCEDURE CODE NOT ON FILE
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4056	THIRD OTHER PROCEDURE CODE NOT ON FILE
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE
4059	REVENUE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4059	REVENUE CODE NOT ON FILE
4061	BPA-RR - NO RULE FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4061	BPA-RR - NO RULE FOR CLAIM TYPE
4062	BPA-RR - NO RULE FOR COND CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4062	BPA-RR - NO RULE FOR COND CODE
4064	BPA-RP-ICD - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4064	BPA-RP-ICD - GENDER RESTRICTION
4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION
4075	BPA-RP-ICD - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed	4075	BPA-RP-ICD - FAMILY PLANNING IND RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
4077	NON-COVERED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4077	NON-COVERED REVENUE CODE
4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION
4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION
4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION
4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION
4112	BPA-PC-ICD - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4112	BPA-PC-ICD - FAMILY PLANNING IND RESTRICTION
4117	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4117	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION
4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION
4120	ORAL CAVITY DESIGNATION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied	4120	ORAL CAVITY DESIGNATION CODE INVALID

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			using remittance advice remarks codes whenever appropriate		
4130	PAYER HIERARCHY NOT FOUND	A1	Claim/Service denied.	4130	PAYER HIERARCHY NOT FOUND
4136	BPA-RP-ICD - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4136	BPA-RP-ICD - BILL PROV PRIMARY PT/PS RESTRICTION
4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION
4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION
4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION
4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION
4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION
4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION
4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION
4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION
4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION
4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION
4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION
4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION
4159	BPA-PC-ICD - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4159	BPA-PC-ICD - CURR PROV CONTRACT RESTRICTION
4160	BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4160	BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION
4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION
4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION
4166	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4166	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN
4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN
4177	BPA-PC-ICD - BILL PROV PRIMARY	16	Claim/service lacks	4177	BPA-PC-ICD - BILL PROV PRIMARY

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	PT/PS RESTRICTION		information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		PT/PS RESTRICTION
4194	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4194	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE
4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD
4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION
4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE
4212	BILLING OUT OF CLIA CERTIFICATE TYPE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4212	BILLING OUT OF CLIA CERTIFICATE TYPE
4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL
4224	BPA-RP-PROC - QUANTITY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4224	BPA-RP-PROC - QUANTITY RESTRICTION
4225	INVALID INPATIENT REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4225	INVALID INPATIENT REVENUE CODE
4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice	4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remarks codes whenever appropriate		
4227	BPA-RP-REV - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4227	BPA-RP-REV - NO COVERAGE
4244	BPA-RP-DIAG - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4244	BPA-RP-DIAG - NO COVERAGE
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE
4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4254	BPA-RP-REV - AGE RESTRICTION	6	The procedure code is inconsistent with the patient's age.	4254	BPA-RP-REV - AGE RESTRICTION
4260	NDC REQUIRED FOR PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4260	NDC REQUIRED FOR PROCEDURE
4264	NDC NOT ON THE DRUG FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4264	NDC NOT ON THE DRUG FILE
4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever	4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate		
4266	NDC NOT COVERED - PRIMARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4266	NDC NOT COVERED - PRIMARY NDC NOT ACTIVE ON DOS
4267	NDC NOT COVERED - SECONDARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4267	NDC NOT COVERED - SECONDARY NDC NOT ACTIVE ON DOS
4268	NDC NOT COVERED - NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4268	NDC NOT COVERED - NDC NOT REBATABLE ON DOS
4269	NDC NOT COVERED - SECOND NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4269	NDC NOT COVERED - SECOND NDC NOT REBATABLE ON DOS
4270	NDC NOT COVERED - NDC RATED LESS THAN EFFECTIVE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4270	NDC NOT COVERED - NDC RATED LESS THAN EFFECTIVE
4271	DUPLICATE NDC FOR CLAIM DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4271	DUPLICATE NDC FOR CLAIM DETAIL
4272	NDC NOT COVERED - OBSOLETE OR TERMINATED ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4272	NDC NOT COVERED - OBSOLETE OR TERMINATED ON DOS
4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4
4278	NDC NOT COVERED - NDC NOT EFFECTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4278	NDC NOT COVERED - NDC NOT EFFECTIVE ON THE DOS

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4279	NDC NOT COVERED - NDC INACTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4279	NDC NOT COVERED - NDC INACTIVE ON THE DOS
4280	NDC NOT COVERED - NDC IN REJECT REGARDLESS ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4280	NDC NOT COVERED - NDC IN REJECT REGARDLESS ON DOS
4281	NDC NOT COVERED - REPACKAGED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4281	NDC NOT COVERED - REPACKAGED NDC
4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION
4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION
4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION
4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION
4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION
4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION
4316	BPA-PC -ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed	4316	BPA-PC -ANY DTL DIAG RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
4317	BPA-PC-ICD - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4317	BPA-PC-ICD - ADMIT DIAG RESTRICTION
4318	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4318	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION
4319	BPA-PC-ICD - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4319	BPA-PC-ICD - ANY HDR DIAGNOSIS RESTRICTION
4320	BPA-PC-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4320	BPA-PC-REV - ADMIT DIAG RESTRICTION
4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION
4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION
4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION
4364	BPA-PC-ICD - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4364	BPA-PC-ICD - TYPE OF BILL RESTRICTION
4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied	4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			using remittance advice remarks codes whenever appropriate		
4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION
4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION
4374	BPA-RP-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4374	BPA-RP-REV - CLAIM TYPE RESTRICTION
4376	BPA-RP-ICD - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4376	BPA-RP-ICD - CLAIM TYPE RESTRICTION
4400	BPA-RP-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4400	BPA-RP-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION
4401	BPA-PC-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4401	BPA-PC-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION
4402	BPA-RR-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4402	BPA-RR-PROC - ADMITTING DIAGNOSIS GROUP RESTRICTION
4403	BPA-RP-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4403	BPA-RP-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION
4404	BPA-PC-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4404	BPA-PC-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION
4405	BPA-RR-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4405	BPA-RR-ICD - ADMITTING DIAGNOSIS GROUP RESTRICTION
4406	BPA-RP-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4406	BPA-RP-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION
4407	BPA-PC-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4407	BPA-PC-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION
4408	BPA-RR-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program	4408	BPA-RR-REV - ADMITTING DIAGNOSIS GROUP RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			guidelines were not met or were exceeded.		
4409	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4409	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4410	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4410	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4411	BPA-RR-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4411	BPA-RR-PROC - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4412	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4412	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4413	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4413	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4414	BPA-RR-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4414	BPA-RR-ICD - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4415	BPA-RP-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4415	BPA-RP-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4416	BPA-PC-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4416	BPA-PC-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4417	BPA-RR-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4417	BPA-RR-REV - PRIMARY HDR DIAGNOSIS GROUP RESTRICTION
4418	BPA-RP-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4418	BPA-RP-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4419	BPA-PC-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4419	BPA-PC-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4420	BPA-RR-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4420	BPA-RR-PROC - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4421	BPA-RP-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4421	BPA-RP-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4422	BPA-PC-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4422	BPA-PC-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4423	BPA-RR-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4423	BPA-RR-ICD - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4424	BPA-RP-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or	4424	BPA-RP-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			were exceeded.		
4425	BPA-PC-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4425	BPA-PC-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4426	BPA-RR-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4426	BPA-RR-REV - SECONDARY HDR DIAGNOSIS GROUP RESTRICTION
4427	BPA-RP-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4427	BPA-RP-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4428	BPA-PC-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4428	BPA-PC-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4429	BPA-RR-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4429	BPA-RR-PROC - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4430	BPA-RP-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4430	BPA-RP-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4431	BPA-PC-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4431	BPA-PC-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4432	BPA-RR-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4432	BPA-RR-ICD - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4433	BPA-RP-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4433	BPA-RP-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4434	BPA-PC-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4434	BPA-PC-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4435	BPA-RR-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4435	BPA-RR-REV - OTHER HDR DIAGNOSIS GROUP RESTRICTION
4436	BPA-RP-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4436	BPA-RP-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4437	BPA-PC-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4437	BPA-PC-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4438	BPA-RR-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4438	BPA-RR-PROC - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4439	BPA-RP-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4439	BPA-RP-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4440	BPA-PC-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4440	BPA-PC-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4441	BPA-RR-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4441	BPA-RR-ICD - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4442	BPA-RP-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4442	BPA-RP-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4443	BPA-PC-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4443	BPA-PC-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4444	BPA-RR-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4444	BPA-RR-REV - EMERGENCY DIAGNOSIS GROUP RESTRICTION
4445	BPA-RR-PROC - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4445	BPA-RR-PROC - ANY HDR DIAGNOSIS GROUP RESTRICTION
4446	BPA-RP-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4446	BPA-RP-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION
4447	BPA-PC-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4447	BPA-PC-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION
4448	BPA-RR-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4448	BPA-RR-ICD - ANY HDR DIAGNOSIS GROUP RESTRICTION
4449	BPA-RP-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4449	BPA-RP-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION
4450	BPA-PC-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4450	BPA-PC-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION
4451	BPA-RR-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4451	BPA-RR-REV - ANY HDR DIAGNOSIS GROUP RESTRICTION
4479	BPA-RP-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4479	BPA-RP-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4480	BPA-PC-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4480	BPA-PC-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4481	BPA-RR-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4481	BPA-RR-PROC - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4482	BPA-RP-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4482	BPA-RP-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4483	BPA-PC-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4483	BPA-PC-ICD - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4484	BPA-RR-ICD - OTHER ANY DIAGNOSIS	B5	Payment adjusted because	4484	BPA-RR-ICD - OTHER ANY DIAGNOSIS

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	GROUP RESTRICTION		coverage/program guidelines were not met or were exceeded.		GROUP RESTRICTION
4485	BPA-RP-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4485	BPA-RP-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4486	BPA-PC-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4486	BPA-PC-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4487	BPA-RR-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4487	BPA-RR-REV - OTHER ANY DIAGNOSIS GROUP RESTRICTION
4519	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4519	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION
4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION
4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION
4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION
4523	BPA-RP-ICD - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4523	BPA-RP-ICD - BILL PROV ALL PT/PS RESTRICTION
4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION
4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION
4529	BPA-RP-REV - PROV COUNTY	B7	This provider was not	4529	BPA-RP-REV - PROV COUNTY

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	RESTRICTION		certified/eligible to be paid for this procedure/service on this date of service.		RESTRICTION
4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION
4532	BPA-RR-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4532	BPA-RR-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION
4535	BPA-RP-ICD - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4535	BPA-RP-ICD - EMERGENCY DIAGNOSIS RESTRICTION
4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION
4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION
4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION
4540	BPA-PC-PROC - MIN UNIT RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4540	BPA-PC-PROC - MIN UNIT RESTRICTION
4560	BPA-RP-ICD - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever	4560	BPA-RP-ICD - SECONDARY HDR DIAG RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate		
4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION
4562	BPA-RP-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4562	BPA-RP-REV - GENDER RESTRICTION
4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION
4565	BPA-RR-ICD - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4565	BPA-RR-ICD - HDR SECONDARY DIAG RESTRICTION
4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION
4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP
4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP
4716	BPA-PC-ICD - AGE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4716	BPA-PC-ICD - AGE RESTRICTION
4723	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4723	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4724	BPA-RP-ICD - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4724	BPA-RP-ICD - ANY HDR DIAGNOSIS RESTRICTION
4726	BPA-RP-ICD - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4726	BPA-RP-ICD - ADMIT DIAG RESTRICTION
4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION
4732	BPA-RP-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4732	BPA-RP-REV - ADMIT DIAG RESTRICTION
4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION
4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION
4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION
4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION
4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION
4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed	4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION
4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION
4747	BPA-PC-ICD - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4747	BPA-PC-ICD - HDR SECONDARY DIAG RESTRICTION
4748	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4748	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION
4751	BPA-PC-REV - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4751	BPA-PC-REV - TYPE OF BILL RESTRICTION
4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION
4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION
4762	BPA-PC-ICD - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4762	BPA-PC-ICD - PLACE OF SERVICE RESTRICTION
4765	BPA-RP-ICD - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied	4765	BPA-RP-ICD - NO COVERAGE

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			using remittance advice remarks codes whenever appropriate		
4767	BPA-RP-ICD - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4767	BPA-RP-ICD - PLACE OF SERVICE RESTRICTION
4801	BPA-PC-PROC - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4801	BPA-PC-PROC - NO CONTRACT
4802	BPA-PC-DIAG - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4802	BPA-PC-DIAG - NO CONTRACT
4804	BPA-PC-REV - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4804	BPA-PC-REV - NO CONTRACT
4806	BPA-PC-ICD - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4806	BPA-PC-ICD - NO CONTRACT
4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION
4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION
4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION
4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever	4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate		
4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION
4873	BPA-PC-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4873	BPA-PC-NDC - CLAIM TYPE RESTRICTION
4874	BPA-PC-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4874	BPA-PC-REV - CLAIM TYPE RESTRICTION
4876	BPA-PC-ICD - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4876	BPA-PC-ICD - CLAIM TYPE RESTRICTION
4900	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4900	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION
4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION
4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION
4905	BPA-RP-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4905	BPA-RP-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION
4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION
4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION
4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR
4923	BPA-PC-ICD - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4923	BPA-PC-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION
4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION
4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION
4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION
4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed	4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION
4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION
4940	BPA-RP-ICD - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4940	BPA-RP-ICD - BENE PLAN RESTRICTION
4941	BPA-RP-ICD - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4941	BPA-RP-ICD - CONDITION CODE RESTRICTION
4942	BPA-RP-ICD - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4942	BPA-RP-ICD - OCCURRENCE CODE RESTRICTION
4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION
4944	BPA-PC-ICD - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4944	BPA-PC-ICD - GENDER RESTRICTION
4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION
4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied	4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			using remittance advice remarks codes whenever appropriate		
4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION
4950	BPA-PC-ICD - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4950	BPA-PC-ICD - BENEFIT PLAN RESTRICTION
4951	BPA-PC-ICD - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4951	BPA-PC-ICD - CONDITION CODE RESTRICTION
4952	BPA-PC-ICD - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4952	BPA-PC-ICD - OCCURRENCE CODE RESTRICTION
4960	BPA-RP-NDC - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4960	BPA-RP-NDC - BENE PLAN RESTRICTION
4961	BPA-RP-PROC - PROV COUNTY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4961	BPA-RP-PROC - PROV COUNTY RESTRICTION
4962	BPA-PC-NDC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4962	BPA-PC-NDC - GENDER RESTRICTION
4963	BPA-PC-PROC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4963	BPA-PC-PROC - GENDER RESTRICTION
4964	BPA-PC-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever	4964	BPA-PC-REV - GENDER RESTRICTION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate		
4965	BPA-PC-NDC - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4965	BPA-PC-NDC - BENEFIT PLAN RESTRICTION
4966	BPA-RR - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4966	BPA-RR - DIAGNOSIS RESTRICTION
4970	BPA-RP-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4970	BPA-RP-REV - BENEFIT PLAN RESTRICTION
4971	BPA-RP-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4971	BPA-RP-REV - CONDITION CODE RESTRICTION
4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION
4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION
4975	BPA-PC-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4975	BPA-PC-REV - BENEFIT PLAN RESTRICTION
4976	BPA-PC-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4976	BPA-PC-REV - CONDITION CODE RESTRICTION
4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4981	BPA-RP-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4981	BPA-RP-PROC - CONDITION CODE RESTRICTION
4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION
4991	BPA-PC-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4991	BPA-PC-PROC - CONDITION CODE RESTRICTION
4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION
4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION
4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP	96	Non-covered charge(s).	4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP
5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR
5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR
5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE
5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCE
5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.
5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.
5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or	5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			were exceeded.		
5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE
5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.
5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.
5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE
5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE
5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518
5214	PROCEDURE CODE NOT ALLOWED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5214	PROCEDURE CODE NOT ALLOWED ON THE SAME DAY
5218	SUPPLY CODE CANNOT BE BILLED WITH LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5218	SUPPLY CODE CANNOT BE BILLED WITH LAB OR OFFICE VISIT
5219	SUPPLY CODE HAS BEEN PAID IN HISTORY, CANNOT BILL A LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5219	SUPPLY CODE HAS BEEN PAID IN HISTORY, CANNOT BILL A LAB OR OFFICE VISIT
5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE
5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE
5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH
5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH
5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee	5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			arrangement.		
5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.
5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED
5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS
5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS
5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE
5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB
5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY
5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5285	DME HUMIDIFIER OR CPAP/CPAP CONTRA	A1	Claim/Service denied.	5285	DME HUMIDIFIER OR CPAP/CPAP CONTRA
5286	DME CPAP OR HUMIDIFIER/CPAP CONTRA	A1	Claim/Service denied.	5286	DME CPAP OR HUMIDIFIER/CPAP CONTRA

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5287	DME CATHETER CONTRA FOR A4221	119	Benefit maximum for this time period or occurrence has been reached.	5287	DME CATHETER CONTRA FOR A4221
5288	DME HUMIDIFIER OR BIPAP/BIPAP CONTRA	A1	Claim/Service denied.	5288	DME HUMIDIFIER OR BIPAP/BIPAP CONTRA
5289	DME BIPAP OR HUMIDIFIER/BIPAP CONTRA	A1	Claim/Service denied.	5289	DME BIPAP OR HUMIDIFIER/BIPAP CONTRA
5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE
5314	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program	5314	PULP THERAPY COMBINATION NOT ALLOWED

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			guidelines were not met or were exceeded.		
5315	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5315	PULP THERAPY COMBINATION NOT ALLOWED
5316	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5316	PULP THERAPY COMBINATION NOT ALLOWED
5317	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5317	PULP THERAPY COMBINATION NOT ALLOWED
5318	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5318	PULP THERAPY COMBINATION NOT ALLOWED
5319	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5319	PULP THERAPY COMBINATION NOT ALLOWED
5320	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5320	PULP THERAPY COMBINATION NOT ALLOWED
5321	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5321	PULP THERAPY COMBINATION NOT ALLOWED
5322	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5322	PULP THERAPY COMBINATION NOT ALLOWED
5323	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5323	PULP THERAPY COMBINATION NOT ALLOWED
5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M
5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M
5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION
5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION
5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.
5329	TWO RESTORATIONS NOT COVERED	B5	Payment adjusted because	5329	TWO RESTORATIONS NOT COVERED

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	FOR THE SAME TOOTH NUMBER.		coverage/program guidelines were not met or were exceeded.		FOR THE SAME TOOTH NUMBER.
5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.
5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.
5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL
5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL
5334	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5334	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR
5335	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5335	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR
5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.
5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.
5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.	107	The related or qualifying claim/service was not identified on this claim.	5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.
5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.
5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.
5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING
5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING
5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER
5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER
5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC
5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC
5410	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	5410	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC
5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC
5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.
5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.
5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY
5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY
5430	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5430	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC
5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC
5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.
5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.
5436	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or	5436	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			were exceeded.		
5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION
5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.
5439	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5439	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.
5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION
5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION
5442	FP-LEVONORGESTREL-CONTRA (J7302-5 YR)	119	Benefit maximum for this time period or occurrence has been reached.	5442	FP-LEVONORGESTREL-CONTRA (J7302-5 YR)
5443	FP-LEVONORGESTREL-CONTRA (Q0090-3 YR)	119	Benefit maximum for this time period or occurrence has been reached.	5443	FP-LEVONORGESTREL-CONTRA (Q0090-3 YR)
5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME
5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.
5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.
5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).
5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.
5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.
5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure	5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			that has already been adjudicated.		
5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY
5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY
5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY
5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS
5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS
5480	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5480	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5481	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5481	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5482	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5482	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5483	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5483	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC
5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.
5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE
5488	COMPONENTS OF A CBC MAY NOT BE	B5	Payment adjusted because	5488	COMPONENTS OF A CBC MAY NOT BE

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BILLED ON THE SAME DAY AS A COMPLETE CBC		coverage/program guidelines were not met or were exceeded.		BILLED ON THE SAME DAY AS A COMPLETE CBC
5490	LAB-CHLAMYDIA/GONORRHEA CONTRA	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5490	LAB-CHLAMYDIA/GONORRHEA CONTRA
5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT
5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT
5506	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	5506	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY
5507	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	5507	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY
5508	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	5508	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A
5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A
5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY	119	Benefit maximum for this time period or occurrence has been reached.	5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY
5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.	119	Benefit maximum for this time period or occurrence has been reached.	5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.
5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	119	Benefit maximum for this time period or occurrence	5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			has been reached.		
5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.
5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED
5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED
5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C
5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C
5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL
5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL
5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE
5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE
5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P
5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE
5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE
5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE
5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE
5602	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5602	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.
5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.
5606	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5606	PAYMENT MADE FOR SIMILAR PROCEDURE
5607	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5607	PAYMENT MADE FOR SIMILAR PROCEDURE
5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP
5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP
5610	PROCEDURE CODES 95115, 95117 OR	B5	Payment adjusted because	5610	PROCEDURE CODES 95115, 95117 OR

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC		coverage/program guidelines were not met or were exceeded.		Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC
5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.
5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES
5613	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5613	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES
5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947
5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947
5616	CRITICAL CARE CANNOT BE BILLED ON THE SAME DAY AS PROCEDURE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5616	CRITICAL CARE CANNOT BE BILLED ON THE SAME DAY AS PROCEDURE
5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE
5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM
5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM
5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.
5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.
5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT
5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT
5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY
5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY
5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED	B5	Payment adjusted because coverage/program	5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	ON THE SAME DAY		guidelines were not met or were exceeded.		ON THE SAME DAY
5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY
5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT
5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT
5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.
5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.
5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER
5633	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5633	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY
5634	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	5634	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME
5635	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	5635	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME
5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P
5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P
5638	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5638	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL
5639	HOSPITAL ADMISSION/VISITS MAY NOT	97	The benefit for this service	5639	HOSPITAL ADMISSION/VISITS MAY NOT

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BE BILLED ON OR AFTER OB GLOBAL		is included in the payment/allowance for another service/procedure that has already been adjudicated.		BE BILLED ON OR AFTER OB GLOBAL
5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE
5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE
5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL
5643	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5643	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL
5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY
5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY
5646	POST-OPERATIVE CARE IS INCLUDED IN THE SURGERY FEE AND CANNOT BE BILLED SEPARAT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5646	POST-OPERATIVE CARE IS INCLUDED IN THE SURGERY FEE AND CANNOT BE BILLED SEPARAT
5647	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5647	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH
5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)
5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY
5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY
5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY
5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITIAL CARE.	B5	Payment adjusted because coverage/program	5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITIAL CARE.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			guidelines were not met or were exceeded.		
5664	INITIAL OFFICE VISIT CANNOT BE BILLED ANYTIME WITHIN 3 YEARS OF A PRIOR VISIT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	5664	INITIAL OFFICE VISIT CANNOT BE BILLED ANYTIME WITHIN 3 YEARS OF A PRIOR VISIT
5665	PRIOR VISIT CANNOT BE BILLED WITHIN 3 YEARS PRIOR TO AN INITIAL OFFICE VISIT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	5665	PRIOR VISIT CANNOT BE BILLED WITHIN 3 YEARS PRIOR TO AN INITIAL OFFICE VISIT
5666	NEW PATIENT/EXISTING PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	5666	NEW PATIENT/EXISTING PATIENT
5667	EXISTING PATIENT/NEW PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	5667	EXISTING PATIENT/NEW PATIENT
5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.
5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.
5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.
5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT
5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT
5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or	5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			were exceeded.		
5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.
5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.
5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.
5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT
5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT
5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.
5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.
5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES
5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES
5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY
5733	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5733	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY
5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY
5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY
5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER
5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT
5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY
5751	PROCEDURE NOT COVERED WHEN	B5	Payment adjusted because	5751	PROCEDURE NOT COVERED WHEN

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY		coverage/program guidelines were not met or were exceeded.		BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY
5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY
5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY
5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE
5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE
5760	ESWL PRICING	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	5760	ESWL PRICING
5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA
5791	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5791	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY
5792	PHYSICAL THERAPY APPLIANCES CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	5792	PHYSICAL THERAPY APPLIANCES CONTRA
5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	Duplicate claim/service.	5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR
5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR	18	Duplicate claim/service.	5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR
5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D
5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D
5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.	18	Duplicate claim/service.	5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.
5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.
5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI
5816	HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5816	HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.
5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.
5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.
5820	LTC VENT CANNOT BE BILLED WITHOUT LTC STAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5820	LTC VENT CANNOT BE BILLED WITHOUT LTC STAY
5821	ADD - ON CODE CANNOT BE PAID WITHOUT PAID PRIMARY CODE	107	The related or qualifying claim/service was not identified on this claim.	5821	ADD - ON CODE CANNOT BE PAID WITHOUT PAID PRIMARY CODE
5822	AVASTIN J9035 NEGATIVE CONTRA	204	This service/equipment/drug is not covered under the patients current benefit plan.	5822	AVASTIN J9035 NEGATIVE CONTRA
5823	PACE NH DEPENDENT ON PACE NON-NH BILLING	168	PAYMENT DENIED AS SERVICE(S) HAVE BEEN CONSIDERED UNDER THE PATIENT'S MEDICAL PLAN. BENEFITS ARE NOT AVAILABLE UNDER THIS DENTAL PLAN	5823	PACE NH DEPENDENT ON PACE NON-NH BILLING
5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO
5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD
5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD
6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON	119	Benefit maximum for this time period or occurrence has been reached.	6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON
6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR
6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.
6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.
6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.
6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS
6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.	119	Benefit maximum for this time period or occurrence has been reached.	6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.
6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.
6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT	119	Benefit maximum for this time period or occurrence has been reached.	6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT
6041	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	6041	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE
6042	PROCEDURE LIMITED TO ONCE EVERY 30 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	6042	PROCEDURE LIMITED TO ONCE EVERY 30 DAYS.
6043	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	6043	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE
6044	EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	6044	EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.
6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.	119	Benefit maximum for this time period or occurrence has been reached.	6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.
6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS
6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS
6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS
6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.	119	Benefit maximum for this time period or occurrence has been reached.	6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.
6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS
6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS
6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION
6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.	119	Benefit maximum for this time period or occurrence has been reached.	6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.
6100	DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6100	DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH
6101	DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6101	DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH
6102	DME PROCEDURE LIMITED TO 1 PER 5 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	6102	DME PROCEDURE LIMITED TO 1 PER 5 CALENDAR YEARS
6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.
6104	DME PROCEDURE LIMITED TO 700 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6104	DME PROCEDURE LIMITED TO 700 PER CALENDAR MONTH

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6105	DME CLOSED POUCH TOTAL LIMIT OF 60 PER CAL MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6105	DME CLOSED POUCH TOTAL LIMIT OF 60 PER CAL MONTH
6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH
6107	DME PROCEDURE LIMITED TO 40 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6107	DME PROCEDURE LIMITED TO 40 PER CALENDAR MONTH
6108	DME WC PRESSURE PAD TOTAL LIMIT OF 1 PER CAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6108	DME WC PRESSURE PAD TOTAL LIMIT OF 1 PER CAL YEAR
6109	PROCEDURE CODE IS LIMITED TO 100 PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6109	PROCEDURE CODE IS LIMITED TO 100 PER MONTH
6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE
6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.
6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.
6113	DME CODES LIMITED TO THIRTY-ONE UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6113	DME CODES LIMITED TO THIRTY-ONE UNITS PER MONTH
6114	DME PROCEDURE LIMITED TO 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6114	DME PROCEDURE LIMITED TO 2 PER CALENDAR YEAR
6115	MEDICAL SUPPLIES LIMIT IS \$1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA	119	Benefit maximum for this time period or occurrence has been reached.	6115	MEDICAL SUPPLIES LIMIT IS \$1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA
6116	DME PROCEDURE LIMITED TO 1 PER 4 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	6116	DME PROCEDURE LIMITED TO 1 PER 4 CALENDAR YEARS
6117	DME PROCEDURE LIMITED TO 3 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6117	DME PROCEDURE LIMITED TO 3 PER CALENDAR MONTH
6118	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	6118	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE
6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.
6121	DME PROCEDURE LIMITED TO 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6121	DME PROCEDURE LIMITED TO 1 PER CALENDAR YEAR
6122	LEG BAGS ARE LIMITED TO TWO PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6122	LEG BAGS ARE LIMITED TO TWO PER MONTH
6123	DME PROCEDURE LIMITED TO 8 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6123	DME PROCEDURE LIMITED TO 8 PER CALENDAR YEAR
6124	DME PROCEDURE LIMITED TO 1 PER 3 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	6124	DME PROCEDURE LIMITED TO 1 PER 3 CALENDAR YEARS
6125	DME PROCEDURE LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6125	DME PROCEDURE LIMITED TO 2 PER CALENDAR MONTH
6126	DME PROCEDURE LIMITED TO 120 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6126	DME PROCEDURE LIMITED TO 120 PER CALENDAR MONTH
6128	DME PROCEDURE LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence	6128	DME PROCEDURE LIMITED TO 1 PER CALENDAR MONTH

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			has been reached.		
6129	DME PROCEDURE LIMITED TO 4 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6129	DME PROCEDURE LIMITED TO 4 PER CALENDAR MONTH
6130	DME PROCEDURE LIMITED TO 5 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6130	DME PROCEDURE LIMITED TO 5 PER CALENDAR MONTH
6131	DME PROCEDURE LIMITED TO 10 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6131	DME PROCEDURE LIMITED TO 10 PER CALENDAR MONTH
6132	DME PROCEDURE LIMITED TO 12 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6132	DME PROCEDURE LIMITED TO 12 PER CALENDAR MONTH
6133	DME PROCEDURE LIMITED TO 50 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6133	DME PROCEDURE LIMITED TO 50 PER CALENDAR MONTH
6134	DME PROCEDURE LIMITED TO 90 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6134	DME PROCEDURE LIMITED TO 90 PER CALENDAR MONTH
6135	DME PROCEDURE LIMITED TO 100 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6135	DME PROCEDURE LIMITED TO 100 PER CALENDAR MONTH
6136	DME PROCEDURE LIMITED TO 500 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6136	DME PROCEDURE LIMITED TO 500 PER CALENDAR MONTH
6137	DME PROCEDURE LIMITED TO 1000 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6137	DME PROCEDURE LIMITED TO 1000 PER CALENDAR MONTH
6138	DME PROCEDURE LIMITED TO 1 PER 2 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	6138	DME PROCEDURE LIMITED TO 1 PER 2 CALENDAR YEARS
6139	DME PROCEDURE LIMITED TO 4 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6139	DME PROCEDURE LIMITED TO 4 PER CALENDAR YEAR
6140	DME PROCEDURE RENTAL LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6140	DME PROCEDURE RENTAL LIMITED TO 1 PER CALENDAR MONTH
6141	DME PROCEDURE RENTAL LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6141	DME PROCEDURE RENTAL LIMITED TO 2 PER CALENDAR MONTH
6142	DME PROCEDURE RENTAL LIMITED TO 31 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	6142	DME PROCEDURE RENTAL LIMITED TO 31 PER CALENDAR MONTH
6143	DME BATTERY CHARGER TOTAL LIMIT OF 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6143	DME BATTERY CHARGER TOTAL LIMIT OF 1 PER CALENDAR YEAR
6144	DME BATTERY TOTAL LIMIT OF 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6144	DME BATTERY TOTAL LIMIT OF 2 PER CALENDAR YEAR
6150	VISION AND HEARING SCREENING ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6150	VISION AND HEARING SCREENING ONE PER YEAR
6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME
6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED
6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED
6154	MAXIMUM UNIT LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	6154	MAXIMUM UNIT LIMIT HAS BEEN EXCEEDED.

Provider Remittance Advice (RA) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.
6179	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	6179	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.
6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED
6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED
6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED
6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.
6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED
6185	EYE LENS LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	6185	EYE LENS LIMIT LESS THAN 21
6186	EYE FRAME LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	6186	EYE FRAME LIMIT LESS THAN 21
6187	EYE EXAM LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	6187	EYE EXAM LIMIT LESS THAN 21
6188	EYE FITTING LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	6188	EYE FITTING LIMIT LESS THAN 21
6189	EYE EXAM LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	6189	EYE EXAM LIMIT 1 PER 3 YR (21 AND OLDER)
6190	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	6190	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND OLDER)
6191	EYE REFRACTION LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	6191	EYE REFRACTION LIMIT LESS THAN 21
6192	EYE REFRACTION LIMIT 1 PER 2 YEARS (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	6192	EYE REFRACTION LIMIT 1 PER 2 YEARS (21 AND OLDER)
6193	EYE EXAM LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	6193	EYE EXAM LIMIT 1 PER 3 YR (21 AND >)
6194	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	6194	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND >)
6195	EYE FRAME LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	6195	EYE FRAME LIMIT 1 PER 3 YR (21 AND >)
6196	EYE LENS LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	6196	EYE LENS LIMIT 1 PER 3 YR (21 AND >)
6197	EYE FITTING LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	6197	EYE FITTING LIMIT 1 PER 3 YR (21 AND >)
6200	THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	6200	THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.
6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER	119	Benefit maximum for this time period or occurrence	6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	YEAR.		has been reached.		YEAR.
6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED
6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.
6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME
6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR
6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977	119	Benefit maximum for this time period or occurrence has been reached.	6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977
6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O
6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.
6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.
6211	DEPO-PROVERA INJECTION LIMITED TO ONE PER EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	6211	DEPO-PROVERA INJECTION LIMITED TO ONE PER EVERY 70 DAYS.
6212	FP-LEVONORGESTREL-IU LIMIT-1 PER 3 YRS	119	Benefit maximum for this time period or occurrence has been reached.	6212	FP-LEVONORGESTREL-IU LIMIT-1 PER 3 YRS

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